Senate

General Assembly **File No. 361**

January Session, 2019 Substitute Senate Bill No. 134

Senate, April 3, 2019

The Committee on Insurance and Real Estate reported through SEN. LESSER of the 9th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING PUBLIC OPTIONS FOR HEALTH CARE IN CONNECTICUT.

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

Section 1. (NEW) (*Effective July 1, 2019*) For the purposes of this section and sections 2 to 5, inclusive, of this act:

(1) "Account" means the ConnectHealth Trust Account established under section 4 of this act;

(2) "Advisory council" means the ConnectHealth Advisory Council established under section 3 of this act;

(3) "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act, P.L. 111-152, as both may be amended from time to time, and regulations adopted thereunder;

(4) "ConnectHealth Plan" means the health benefit plan designed and made available to individuals in this state as part of the program;

(5) "Essential health benefits" means benefits that are essential health benefits within the meaning of (A) the Affordable Care Act, or (B) sections 38a-492q and 38a-518q of the general statutes;

(6) "Exchange" means the Connecticut Health Insurance Exchange established under section 38a-1081 of the general statutes;

(7) "Health benefit plan" has the same meaning as provided in section 38a-1080 of the general statutes;

(8) "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;

(9) "Program" means the ConnectHealth Program established by the Comptroller pursuant to section 2 of this act;

(10) "Qualified health plan" has the same meaning as provided in section 38a-1080 of the general statutes; and

(11) "Third-party administrator" has the same meaning as provided in section 38a-720 of the general statutes.

Sec. 2. (NEW) (*Effective July 1, 2019*) (a) The Comptroller shall, within available appropriations and in consultation with the advisory council and the Office of Health Strategy, establish a program to be known as the "ConnectHealth Program". The purpose of the program shall be to offer high-quality, low-cost health insurance coverage to enrollees in this state under a ConnectHealth Plan. Under the program, the Comptroller, in consultation with the advisory council and the Office of Health Strategy, shall:

(1) Establish enrollment criteria for the ConnectHealth Plan;

(2) Design and offer the ConnectHealth Plan, which shall, at a minimum: (A) Be made available to prospective enrollees in this state not later than January 1, 2021; (B) provide coverage for essential health benefits; (C) provide a level of covered benefits that meets or exceeds

the level of covered benefits provided under qualified health plans; (D) impose premiums, deductibles and enrollee cost-sharing in amounts that do not exceed the amounts imposed under qualified health plans; and (E) include an affordability scale for premiums, deductibles and enrollee cost-sharing that varies according to an enrollee's household income;

(3) Determine whether to offer the ConnectHealth Plan through the exchange as a qualified health plan;

(4) Subject to the provisions of subsection (c) of this section: (A) Establish a schedule of payments and reimbursement rates for the ConnectHealth Plan; (B) provide, within available appropriations, state-financed cost-sharing subsidies to enrollees in the ConnectHealth Plan who do not qualify for cost-sharing subsidies under the Affordable Care Act; and (C) seek a waiver from the United States Department of the Treasury or the United States Department of Health and Human Services, as applicable, pursuant to Section 1332 of the Affordable Care Act;

(5) Use any data submitted to the all-payer claims database program established under section 19a-755a of the general statutes to evaluate, on an ongoing basis, the impact of the ConnectHealth Plan on: (A) Individuals in this state; (B) health care providers and health care facilities in this state; and (C) the individual and group health insurance markets in this state; and

(6) Implement a competitive process to select, and enter into a contract with, one or more third-party administrators to administer the ConnectHealth Plan, and permit such third-party administrator or third-party administrators to directly receive individual premiums and federal premium tax credits in accordance with all applicable provisions of the Affordable Care Act and the Internal Revenue Code.

(b) The Comptroller may, in the Comptroller's discretion and within available appropriations, engage the services of such third-party actuaries, professionals and specialists that the Comptroller deems

necessary to assist the Comptroller in performing the Comptroller's duties under subsection (a) of this section.

(c) (1) Not later than March 1, 2020, the Comptroller, in consultation with the advisory council and the Office of Health Strategy, shall submit, in accordance with section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance:

(A) A plan to make the ConnectHealth Plan available to prospective enrollees in this state not later than January 1, 2021;

(B) Strategies to ensure that health care providers and health care facilities in this state participate in the ConnectHealth Plan;

(C) An analysis of the likely impact of the ConnectHealth Plan on the individual and group health insurance markets in this state;

(D) A proposed schedule of the initial payments and reimbursement rates for the ConnectHealth Plan;

(E) A proposal to implement state-financed cost-sharing subsidies for enrollees in the ConnectHealth Plan who do not qualify for cost-sharing subsidies under the Affordable Care Act, which proposal shall include, but need not be limited to, (i) eligibility criteria for enrollees to receive such subsidies, (ii) the recommended amount or amounts of such subsidies, and (iii) a plan to administer and disburse such subsidies; and

(F) A proposed application for a waiver from the United States Department of the Treasury or the United States Department of Health and Human Services, as applicable, pursuant to Section 1332 of the Affordable Care Act.

(2) If the committee does not act within sixty days after receiving a submittal under subdivision (1) of this subsection, each proposal described in subparagraphs (D) to (F), inclusive, of said subdivision shall be deemed to be denied by the committee.

Sec. 3. (NEW) (*Effective July 1, 2019*) (a) (1) There is established the ConnectHealth Advisory Council. The council shall consist of ten members, as follows:

(A) Two appointed by the speaker of the House of Representatives, one of whom shall represent the interests of hospitals in this state and one of whom shall represent the interests of community-based health care providers in this state;

(B) Two appointed by the president pro tempore of the Senate, one of whom shall represent the interests of consumers in this state and one of whom shall represent the interests of nurses practicing in this state;

(C) One appointed by the majority leader of the House of Representatives, who shall represent the interests of patients in this state;

(D) One appointed by the majority leader of the Senate, who shall have expertise in health policy;

(E) Two appointed by the minority leader of the House of Representatives, one of whom shall represent the interests of health insurers offering individual health insurance policies in this state and one of whom shall represent the interests of physicians practicing in this state; and

(F) Two appointed by the minority leader of the Senate, one of whom shall represent the interests of health insurers offering small group health insurance policies in this state and one of whom shall represent the interests of insurance producers licensed in this state.

(2) The members of the advisory council shall select a chairperson from the membership of the advisory council, and the advisory council may establish rules governing the advisory council's internal procedures.

(3) The Governor, Lieutenant Governor, Comptroller, Secretary of

the Office of Policy and Management, Insurance Commissioner and Commissioner of Social Services shall serve as ex-officio, nonvoting members of the advisory council.

(b) Initial appointments to the advisory council shall be made on or before October 1, 2019. If an appointing authority fails to appoint an advisory council member on or before October 1, 2019, the president pro tempore of the Senate and the speaker of the House of Representatives shall jointly appoint an advisory council member meeting the required specifications on behalf of such appointing authority and such advisory council member shall serve a full term. The presence of not less than six advisory council members shall constitute a quorum for the transaction of business. The initial term for advisory council members appointed by the minority leader of the House of Representatives and the minority leader of the Senate shall be three years. The initial term for advisory council members appointed by the majority leader of the House of Representatives and the majority leader of the Senate shall be four years. The initial term for the advisory council members appointed by the speaker of the House of Representatives and the president pro tempore of the Senate shall be five years. Terms pursuant to this subsection shall expire on June thirtieth in accordance with the provisions of this subsection. Any vacancy shall be filled by the appointing authority for the balance of the unexpired term. Not later than thirty days prior to the expiration of a term as provided for in this subsection, the appointing authority may reappoint the current advisory council member or shall appoint a new member to the advisory council. Other than an initial term, an advisory council member shall serve for a term of five years and until a successor advisory council member is appointed. Each member of the advisory council shall be eligible for reappointment. Any member of the advisory council may be removed by the appropriate appointing authority for misfeasance, malfeasance or wilful neglect of duty.

(c) The advisory council shall advise the Comptroller and the Office of Health Strategy on matters concerning the ConnectHealth Program and the ConnectHealth Plan, including, but not limited to:

(1) Implementation of the ConnectHealth Plan;

(2) Affordability of the ConnectHealth Plan;

(3) Marketing of the ConnectHealth Plan to prospective enrollees;

(4) Outreach to prospective enrollees and enrollees in the ConnectHealth Plan; and

(5) Periodic evaluations of the ConnectHealth Plan.

(d) The advisory council shall not be construed to be a department, institution or agency of this state. The staff of the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall provide administrative support to the advisory council.

Sec. 4. (NEW) (*Effective July 1, 2019*) There is established an account to be known as the "ConnectHealth Trust Account", which shall be a separate, nonlapsing account within the General Fund. The account shall contain all moneys required by law to be deposited in the account. Investment earnings from any moneys in the account shall be credited to the account and shall become part of the assets of the account. Any balance remaining in the account at the end of any fiscal year shall be carried forward in the account for the fiscal year next succeeding. The moneys in the account shall be allocated to the Comptroller for the purposes of lowering the cost of the ConnectHealth Plan and providing state-financed cost-sharing subsidies to enrollees in such plan who do not qualify for cost-sharing subsidies under the Affordable Care Act.

Sec. 5. (NEW) (*Effective July 1, 2019*) The Comptroller may adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of sections 1 to 4, inclusive, of this act.

Sec. 6. Section 3-123rrr of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

As used in this section, section 7 of this act and sections 3-123sss to 3-123vvv, inclusive, as amended by this act:

(1) "Health Care Cost 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.

(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) "Small employer" means an employer, other than a nonstate public employer, that employed an average of at least one but not more than fifty employees on business days during the preceding calendar year, and employs at least one employee on the first day that such employer receives coverage under a group hospitalization, medical, pharmacy and surgical insurance plan offered by the Comptroller pursuant to this part.

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

Sec. 7. (NEW) (*Effective July 1, 2019*) (a) Notwithstanding any provision of title 38a of the general statutes, the Comptroller shall offer to small employers and their employees coverage under the state employee plan or another group hospitalization, medical, pharmacy and surgical insurance plan developed by the Comptroller to provide coverage for small employers and their employees. A small employer and its employees receiving coverage provided pursuant to this section shall be pooled with state employees and retirees under the state employee plan, provided the small employer files an application with

the Comptroller for coverage pursuant to this section and the Comptroller approves such application. Small employers shall remit to the Comptroller payments for coverage provided pursuant to this section. Such payments shall be equal to the payments paid by the state for state employees covered under the state employee plan, inclusive of any premiums paid by state employees pursuant to the state employee plan, except that premium payments may be adjusted to reflect the cost of health care in the geographic area in which the majority of a small employer's employees work, differences from the benefits and networks provided to state employees, the demographic makeup of the small employer's employees or as otherwise provided in this section. The Comptroller shall phase in the geographic adjustment established in this subsection over a two-year period for existing participants. Beginning on 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.

(b) The Comptroller shall offer participation in each plan described in subsection (a) of this section for intervals lasting not less than three years. A small employer may apply for renewal of coverage prior to expiration of each interval.

(c) The Comptroller shall develop procedures by which small employers may initially apply for, renew and withdraw from coverage provided pursuant to this section, as well as rules of participation that the Comptroller, in the Comptroller's discretion, deems necessary.

(d) The Comptroller shall establish accounting procedures to track claims and premium payments paid by small employers receiving coverage provided pursuant to this section.

Sec. 8. Subsections (a) to (c), inclusive, of section 3-123sss of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) Notwithstanding any provision of title 38a, the Comptroller shall offer to nonstate public employers and their nonstate public

employees, and their retirees, if applicable, coverage under the state employee plan or another group hospitalization, medical, pharmacy and surgical insurance plan developed by the Comptroller to provide coverage for nonstate public employees and their retirees, if applicable. 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 3-123ttt. 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 that premium payments may be adjusted to reflect the cost of health care in the geographic area in which the majority of the nonstate public employer's employees work, differences from the benefits and networks provided to state employees or as otherwise provided in this section or section 3-123uuu, as amended by 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.

(c) Nothing in sections 3-123rrr to 3-123vvv, inclusive, as amended by 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, or (3) prevent the Comptroller from offering plans other than the plans offered to state employees on July 1, 2019, provided no such plan shall be offered if such plan qualifies as a high deductible health plan, as defined in Section 220(c)(2) or Section 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, and is used to establish a medical savings account or an Archer MSA pursuant to said Section 220 or a health savings account pursuant to said Section 223.

Sec. 9. Section 3-123uuu of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

[(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 Cost Containment Committee, for payment of claims and administrative fees to entities providing coverage or services under the state employee plan.**]**

[(b)**]** (a) 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.

(b) The Comptroller shall establish accounting procedures to track claims and premium payments paid by nonstate public employers.

(c) If any payment due by a nonstate public employer under this [subsection] section 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. 10. Section 3-123vvv of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

The Comptroller shall not offer coverage under the state employee plan pursuant to sections 3-123rrr to 3-123uuu, inclusive, as amended by this act, or section 7 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 3-123rrr to 3-123uuu, inclusive, as amended by this act, and section 7 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, 2019*	New section

Sec. 2	*July 1, 2019*	New section
Sec. 3	*July 1, 2019*	New section
Sec. 4	*July 1, 2019*	New section
Sec. 5	*July 1, 2019*	New section
Sec. 6	*July 1, 2019*	3-123rrr
Sec. 7	*July 1, 2019*	New section
Sec. 8	*July 1, 2019*	3-123sss(a) to (c)
Sec. 9	*July 1, 2019*	3-123uuu
Sec. 10	*July 1, 2019*	3-123vvv

Statement of Legislative Commissioners:

In Section 1(5), "or" was substituted for "and" for accuracy; in Section 1(9), "ConnectHealth Program" was substituted for "program" for consistency; in Section 3(b), "If" was substituted for "In the event that" for conciseness; and in Section 3(c)(3), "of" was inserted after "Marketing" for consistency.

INS *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 20 $	FY 21 $
Comptroller; State Comptroller - Fringe Benefits[1]	GF - Cost	At least $1.5 million	At least $750,000
State Comptroller - Fringe Benefits (State Employee and Retiree Health Plan)	GF&TF - See Below	See Below	See Below
University of Connecticut	Operating Funds – See Below	See Below	See Below
Dept. of Revenue Services	GF-Potential Revenue Loss	See Below	See Below

Note: GF=General Fund; TF= Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 20 $	FY 21 $
Various Municipalities Participating in the Partnership Plan	See Below	See Below	See Below

Explanation

The bill will result in a cost to the Office of the State Comptroller (OSC) of approximately $1.5 million in FY 20 and up to $750,000 FY 21, as described below. In addition, the bill will result in the fiscal impact described below to the state employee and retiree health plan, the University of Connecticut, nonstate public employers participating in the Partnership Plan[2], and the Department of Revenue Services. The fiscal impact is related to the following: (1) establishing the

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 41.19% of payroll in FY 20 and FY 21.

[2] Partnership Plan refers to Partnership 2.0 operated by the Office of the State Comptroller.

ConnectHealth Plan for individuals in accordance with the bill, (2) allowing certain small employers to pool with the state employee health plan for coverage, (4) potential costs associated with the Employee Retirement Income Security Act (ERISA), and (5) potential General Fund revenue loss from the Insurance Premium tax.

Sections 1 – 5 will result in a cost to OSC of at least $1.5 million in FY 20 and $750,000 in FY 21 to establish the ConnectHealth Plan for individuals in consultation with the advisory council (section 3) for coverage beginning January 1, 2021 (FY 21). The cost is associated with consulting services, including but not limited to actuarial and legal services to assist with the plan design requirements, insurance industry impact study, state financed subsidy proposal, and application for a 1332 waiver as required by the bill.[3,4] The bill requires OSC to contract with a third party administrator (TPA)to administer the plan, therefore the cost to OSC after the initial design and implementation period is anticipated to be less depending on how the plan administration is structured.[5]

Lastly, the bill does not specify the amount of state financed subsidies that will be provided to plan participants. The cost to the state will depend on the amount of the subsidies and eligible population determined by OSC and the advisory committee.

Sections 6 – 10 may result in a cost to OSC for two additional Retirement and Benefit Officers to support certain small employers joining the state employee and retiree health plan or other plan

[3] The cost is based on accessing consulting costs incurred for the state employee and retiree health plan, waiver estimates for the Department of Social Services and proposals similar in scope.

[4] State Innovation Waivers were made available beginning January 1, 2017 under the Affordable Care Act. State Innovation Waivers are approved for five-year periods, and can be renewed. Waivers must not increase the Federal deficit. https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/section_1332_state_innovation_waivers-.html#Section%201332%20State%20Application%20Waiver%20Applications

[5] OSC currently utilizes a TPA for the Partnership Plan and the state employee plan in addition to state agency staff.

provided by OSC, including the Partnership Plan starting in FY 20.[6] The total annualized salary and fringe benefit costs associated with two additional positions is approximately $178,500.[7] In addition, there may be administrative costs related to actuarial services to evaluate a small employer's risk, member support and outreach for participating entities which may be offset by administrative fees OSC is allowed to charge starting in FY 21.

In addition, allowing certain small employers to pool with the state plan, as required by the bill, may result in a fiscal impact to the state employee and retiree health plan, the University of Connecticut related to unionized graduate assistants and certain nonstate public employers including municipalities who participate in the Partnership Plan. The impact will depend on the risk of the pooled participants as reflected in the premiums/premium equivalents established in accordance with the bill and current law.[8]

The state employee and retiree health plan (excluding the Medicare Advantage Plan for employees and dependents age 65 and older) is a self-insured plan. Currently, state employees, retirees, unionized graduate assistants at the University of Connecticut, nonstate public employers participating in the Partnership Plan, and all eligible dependents are pooled into a single risk pool. Premiums for the state employee and retiree health plan and the Partnership Plan are calculated based on the risk profile of the single pool and identical under current law. To the extent small employers are pooled with the existing risk pool, there could be an impact to the state, participating nonstate public employers and the University of Connecticut. In addition, as a self-insured pool, the state currently bears the risk for costs incurred in excess of plan premiums. The state does not currently

[6] Participation in the state employee and retiree health plan is contingent on approval by the State Employees' Bargaining Agent Coalition (SEBAC).

[7] Based on entry level annual salary for a retirement benefits officer of approximately $63,200.

[8] The bill requires premiums to be the same as those for state employees but allows for specific adjustments including but not limited to geographic rating and demographics specific to the small employer.

have stop-loss insurance. To the extent claims are in excess of the premiums established, there will be a cost to the state.

Lastly, section 8, will result in a fiscal impact to nonstate public employers including municipalities who currently participate in the Partnership Plan to the extent: (1) additional plans or plan designs are developed by OSC, excluding high deductible plans, and (2) geographical rating impacts the premiums nonstate public employers currently pay to OSC starting in FY 20. In addition, section 8, eliminates the requirement to refund any premiums in excess of claims, which will result in a reserve to the extent this occurs. While this provision would preclude any potential savings from accruing to participating entities for a single plan year, reserves will mitigate future premium increases necessary to cover plan losses.

Section 9 eliminates the state employee premium account. This account pays claims costs for nonstate public employers participating in the Partnership Plan out of plan premiums currently deposited into the account. It is unclear to what extent OSC is permitted to receive premiums paid by nonstate public employers, including small employers, without a designated account within the General Fund as is provided in current law. The bill requires OSC to establish an accounting procedure. The bill does not specify how the funds currently in the account will be accounted for.

Employee Retirement Income Security Act (ERISA) ***Impact***

As a self-insured governmental plan, the state plan is exempt from US Department of Labor ERISA regulations. To the extent small employers are pooled with the state employee plan the state plan could lose its ERISA exemption.[9] Under ERISA, the state would have

[9]The issue was pursued by the Malloy Administration in 2012 with regards to the Partnership Plan allowing small employers to pool with the state plan. https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/2012-01a

to comply with fiduciary standards, reporting and disclosure requirements. Failure to comply with ERISA could subject the state to financial penalties and "gives participants the right to sue for benefits and breaches of fiduciary duty".[10]

Loss of Revenue

Pursuant to CGS Sec. 12-202 carriers pay an Insurance Premiums Tax to the state of 1.5% on all net direct premiums underwritten. To the extent individuals and small employers shift into plans operated by OSC not subject to the tax, the state will experience a General Fund revenue loss. The state collected $209 million from the Insurance Premiums Tax in FY 18. [11]

The Out Years

The annualized ongoing fiscal impact identified will continue into the future based on: (1) the design and implementation of the ConnectHealth Plan including the amount of state financed subsidies, (2) impact to the state employee and retiree health plan and Partnership Plan risk pool, (3) administrative costs associated with ERISA, and (3) the impact to Insurance Premium Tax revenue.

[10] Source: US Department of Labor:
https://www.dol.gov/general/topic/health-plans/erisa
[11] Source: Dept. of Revenue Services Annual Report (2018).

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 Authority	*Number of Appointments*	*Initial Term*	*Appointees*
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)