SUMMARY

This bill requires most state residents to maintain minimum essential health coverage beginning January 1, 2020 (§ 1). This is referred to as the “individual mandate.” It exempts from its requirement certain people, including those with a certified religious exemption.

The bill requires the Department of Revenue Services (DRS) commissioner to report to the Insurance and Real Estate Committee by October 1, 2019, with recommendations for (1) how to enforce the individual mandate, including by imposing an individual health care responsibility fee, and (2) a refundable personal income tax credit to help residents offset the cost of health coverage (§ 2). The DRS commissioner must do this in consultation with the insurance commissioner, the Office of Health Strategy executive director, and the Connecticut health insurance exchange (i.e., Access Health CT or “the exchange”).

The bill also requires the following:

1. health carriers (e.g., insurers and HMOs) to pay a surcharge, which is calculated monthly based on the type and number of policies written and lives covered, to the insurance commissioner for deposit into the Connecticut Health Insurance Exchange Fund (§ 3);

2. the exchange to establish and administer, separate from all other accounts and funds, the Connecticut Health Insurance Exchange
Fund to provide funding for (a) state-financed health insurance premium and cost-sharing subsidies to state residents and (b) a reinsurance program to decrease the cost of health insurance in the state (§§ 4-6); and

3. the exchange to (a) grant certain people religious exemptions from the individual mandate and (b) provide the DRS commissioner the name and taxpayer identification number of each exempted person, as well as other tax-related information currently provided to the U.S. Treasury secretary (§ 6).

Additionally, the bill requires health carriers with at least 5,000 individual or group health insurance policies in the state during a calendar year beginning on or after January 1, 2020, to offer for the next plan year at least one qualified health plan through the exchange (§ 7). Similarly, it requires certain health carriers acting as third-party administrators (TPAs) for the state employee health plans offered through the comptroller’s office to offer at least one qualified health plan through the exchange (§ 8).

The bill also requires the Office of Health Strategy (presumably, the executive director) to report to the Insurance and Real Estate Committee by October 1, 2019, with recommendations about (1) state-financed health insurance premium and cost-sharing subsidies and (2) a reinsurance program to decrease the cost of health insurance in the state (§ 9). The office must do this in consultation with the insurance commissioner, Healthcare Advocate, exchange, and insurance industry.

Lastly, the bill authorizes the insurance commissioner to adopt regulations to implement the individual mandate, health carriers’ surcharge, and requirement that large carriers offer at least one qualified health plan on the exchange (§§ 1, 3 & 7).

**EFFECTIVE DATE:** July 1, 2019, except the provisions requiring certain health carriers and TPAs to offer qualified health plans on the exchange (§§ 7 & 8) are effective October 1, 2019, and the individual mandate (§ 1) is effective January 1, 2020.
§ 1 — INDIVIDUAL MANDATE

The bill requires each resident taxpayer and his or her dependents to maintain minimum essential coverage for each month beginning on or after January 1, 2020, if the individual mandate applies to them.

Under the bill, the individual mandate applies to a person who is a U.S. citizen, national, or alien lawfully present in the United States (“applicable individual”). But it does not apply to someone who (1) is a member of an Indian tribe; (2) is incarcerated, unless he or she is incarcerated pending the disposition of charges; or (3) has received a religious exemption from the exchange (see below).

An applicable individual is deemed to have maintained minimum essential coverage for any month during which the individual is not a state resident because he or she was living abroad or residing in another U.S. state or possession (e.g., Puerto Rico, Guam, or U.S. Virgin Islands).

Minimum Essential Coverage

The bill defines “minimum essential coverage” as coverage under any of the following plans:

1. an individual health insurance policy;
2. an employer-sponsored health plan;
3. a qualified health plan, which is a plan that complies with federal Affordable Care Act requirements;
4. a grandfathered health plan, which is coverage that existed on March 23, 2010, that has not made significant coverage changes since;
5. Medicare;
6. Medicaid;
7. the Children’s Health Insurance Program;
8. medical coverage provided under federal law for the uniformed services (e.g., TriCare), veterans, or Peace Corps volunteers; or

9. the U.S. Department of Defense’s Nonappropriated Fund Health Benefits Program.

Under the bill, “minimum essential coverage” does not include health insurance coverage under the following plans:

1. accident-only, credit-only, or disability income insurance;

2. liability or supplemental liability insurance;

3. workers’ compensation or similar insurance;

4. coverage for on-site medical clinics;

5. coverage for a specified disease or illness;

6. limited scope benefit plans (e.g., offering only dental, vision, long-term care, nursing home care, home health care, or community-based care benefits on a stand-alone basis);

7. hospital indemnity or other fixed indemnity insurance;

8. Medicare supplemental health insurance plans or other supplemental plans; or

9. coverage under which medical care benefits are secondary or incidental to other insurance.

**Religious Exemption**

Under the bill, certain people may claim a religious exemption from the individual mandate. An exemption is available to a person who certifies that he or she is a member of a religious sect or division recognized under federal tax law and who adheres to its established tenants or teachings. It is also available to a person who certifies that he or she is a member of a religious sect or division not recognized under federal tax law but who relies solely on a religious healing method because accepting medical health services is inconsistent with
his or her religious beliefs.

§ 3 — HEALTH CARRIER SURCHARGE

The bill requires health carriers to pay a nonrefundable surcharge to the insurance commissioner, in a form and manner he prescribes, for deposit into the Connecticut Health Insurance Exchange Fund. It prohibits carriers from considering the surcharge as premium or passing it on to an insured person.

Applicability

The surcharge applies to each insurer, HMO, hospital or medical service corporation, fraternal benefit society, or other entity that delivers, issues, renews, amends, or continues individual or group health insurance policies in Connecticut that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, or (4) hospital or medical services.

Surcharge Calculated Monthly

A surcharge applies to each policy providing coverage during all or part of a month. It equals the following amount:

1. for each individual policy, $10 multiplied by the number of people insured under the policy, and

2. for each group policy, $5 multiplied by the number of people insured under the policy.

Surcharge Payment Due Date

The bill requires each health carrier to remit the monthly surcharges to the insurance commissioner annually by April 30 for the preceding calendar year. The carrier must include documentation, as the commissioner prescribes, to substantiate the amount being remitted.

The commissioner must deposit all remitted surcharges in the Connecticut Health Insurance Exchange Fund annually by June 1. (Under the bill, the exchange must establish and administer the fund.)

Surcharge is a Special Purpose Assessment
The bill states that the health carrier surcharge is a special purpose assessment for the purposes of the state’s reciprocity provisions (CGS §12-211). Thus, the reciprocity provisions do not apply unless another jurisdiction imposes a retaliatory assessment on domestic insurers.

Under Connecticut’s reciprocity provision, when another state or foreign country imposes taxes, fees, fines, deposit requirements, or other obligations, restrictions, or prohibitions against Connecticut insurance companies doing business there that exceed amounts Connecticut imposes on their insurance companies operating here, Connecticut law imposes an equivalent retaliatory charge or restriction on the other jurisdiction’s companies doing business in Connecticut. This reciprocity provision does not apply to special purpose assessments imposed on certain insurance products unless another jurisdiction retaliates against Connecticut insurers because Connecticut imposes charges on that jurisdiction’s insurers.

§§ 5 & 6 — DUTIES OF THE EXCHANGE

The bill expands the exchange’s statutory duties to include the following:

1. establish and administer the Connecticut Health Insurance Exchange Fund to provide funding for (a) state-financed health insurance premium and cost-sharing subsidies to state residents and (b) a reinsurance program to decrease the cost of health insurance in the state;

2. grant religious exemptions from the individual mandate to qualifying people; and

3. provide the DRS commissioner the name and taxpayer identification number of each person granted a religious exemption.

By law, the exchange must provide certain taxpayer information to the U.S. Treasury secretary. The bill also requires the exchange to provide the same information to the DRS commissioner. Thus, the exchange must provide the commissioner with the names and
taxpayer identification numbers for people:

1. exempt from the federal Affordable Care Act individual mandate requirement;

2. eligible for a federal premium tax credit because their employers failed to provide minimum essential coverage or whose employer-provided coverage was unaffordable under federal tax law;

3. who notified the exchange, pursuant to the Affordable Care Act, that they changed employers; or

4. who ceased coverage under a qualified health plan during the plan year, and the effective date of the coverage cessation.

§§ 7 & 8 — HEALTH CARRIERS AND THIRD-PARTY ADMINISTRATORS REQUIRED TO OFFER AN EXCHANGE PLAN

Health Carriers

Under the bill, certain large health carriers must offer at least one qualified health plan through the exchange.

This applies to each insurer, HMO, hospital or medical service corporation, fraternal benefit society, or other entity that delivers, issues, renews, amends, or continues at least 5,000 individual or group health insurance policies in Connecticut during a calendar year beginning on or after January 1, 2020, that cover basic hospital expenses, basic medical-surgical expenses, major medical expenses, or hospital or medical services.

Third-Party Administrators (TPA)

Similarly, the bill requires certain TPAs for the state employee health plans offered through the comptroller’s office to offer at least one qualified health plan through the exchange.

By law, the comptroller may enter into contracts with TPAs to provide administrative services for the self-insured state employee health plans. The law requires such a TPA to charge the state its lowest
available rate for the services.

The bill also requires such a TPA to offer at least one qualified health plan through the exchange for each plan year beginning on or after January 1, 2020, during the term of its contract with the state, if the:

1. contract begins on or after October 1, 2019, and

2. TPA is an insurer, HMO, hospital or medical service corporation, fraternal benefit society, or other entity authorized to transact health insurance in the state that delivered, issued, renewed, amended, or continued at least 5,000 individual or group health insurance policies in Connecticut covering basic hospital expenses, basic medical-surgical expenses, major medical expenses, or hospital or medical services during the calendar year preceding the plan year.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 11  Nay 9  (03/19/2019)