General Assembly

Amendment

January Session, 2019

LCO No. **9710**

HB07267097 10HDO

Offered by:
REP. SCANLON, 98th Dist.
SEN. LESSER, 9th Dist.

To: Subst. House Bill No. **7267** File No. 353 Cal. No. 231

"AN ACT CONCERNING PUBLIC OPTIONS FOR HEALTH CARE IN CONNECTICUT."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. (NEW) (*Effective July 1, 2019*) For the purposes of this section and sections 2 to 4, inclusive, of this act:

(1) "Advisory council" means the Connecticut Option Advisory Council established under section 3 of this act;

(2) "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;

(3) "Benchmark premium savings target" means the target described in subparagraph (B) of subdivision (1) of subsection (a) of section 2 of this act;

(4) "Connecticut Option" means the health benefit plans designed by the office pursuant to section 2 of this act;

(5) "Executive director" means the executive director of the office;

(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, as amended by this act;

(8) "Health carrier" has the same meaning as provided in section 38a-1080 of the general statutes, as amended by this act;

(9) "Office" means the Office of Health Strategy established under section 19a-754a of the general statutes, as amended by this act;

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

(11) "Value-based insurance design" means health benefit design that lowers or removes financial barriers to essential, high value clinical services.

Sec. 2. (NEW) (*Effective July 1, 2019*) (a) The office, in consultation with the advisory council, shall design the Connecticut Option, which shall be comprised of health benefit plans that provide high-quality, low-cost coverage in the individual and small employer health insurance markets in this state. The office, in consultation with the advisory council, shall:

(1) Design and establish criteria for the health benefit plans comprising the Connecticut Option that:

(A) Ensure that such health benefit plans initially provide coverage not later than January 1, 2022;

(B) For the plan year beginning on January 1, 2022, establish a schedule of payments and reimbursement rates, and benefit and

network designs, to meet the benchmark premium savings target for such plan year, which target shall:

(i) Achieve actuarially sound premiums that are at least twenty per cent lower than the average premiums of the individual and small group plans available on the exchange for plan year 2020 that use the broadest preferred provider network available for each qualified health plan available, which average premium shall be adjusted annually to reflect:

(I) Medical inflation;

(II) Changes in federal or state laws or regulations affecting health insurance premiums; and

(III) Any changes that the Insurance Commissioner, in the commissioner's discretion, believes are affecting the health insurance market or one or more health carriers delivering, issuing for delivery, renewing, amending or continuing such health benefit plans; and

(ii) Not increase the annual amount of coinsurance, copayments, deductibles and other out-of-pocket expenses;

(C) Encourage health carriers and participating providers to enter into contracts that promote improved health care quality, efficiency, care coordination and chronic disease management, which criteria shall include, but need not be limited to, improved primary care reimbursement rates, improved primary care reimbursement structures and minimum quality standards;

(D) Ensure that value-based insurance design is included in all plan offerings under each health benefit plan comprising part of the Connecticut Option, including, but not limited to, prescription drug benefits and first dollar out-of-pocket expenses incurred by plan participants;

(E) Promote increased collaboration by federally qualified health centers and community providers with other providers, including, but

not limited to, acute care hospitals, to ensure better care coordination and access to care; and

(F) Comply with all applicable provisions of title 38a of the general statutes and all regulations adopted thereunder, including, but not limited to:

(i) All network adequacy standards established in section 38a-472f of the general statutes, and any regulations adopted thereunder; and

(ii) All standards concerning pharmacy benefits managers established in sections 38a-479aaa to 38a-479iii, inclusive, of the general statutes, and any regulations adopted thereunder;

(2) Utilize 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 Connecticut Option on:

(A) Individuals in this state;

(B) Health care providers and health care facilities in this state;

(C) The individual and small employer health insurance markets in this state; and

(D) The quality of care provided to participants;

(3) Develop strategies to ensure that health care providers and health care facilities in this state participate in the Connecticut Option;

(4) Establish eligibility criteria to ensure that each health benefit plan comprising part of the Connecticut Option, providing coverage in the individual health insurance market and not offered through the exchange is available to each resident of this state;

(5) (A) Determine whether this state should seek an innovation 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 for the

Connecticut Option, and whether implementation of any aspect of the Connecticut Option shall be contingent on approval of such waiver; and

(B) Seek an innovation 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 to establish a reinsurance program pursuant to subsection (f) of section 31 of this act; and

(6) Disclose to the Insurance Commissioner any information that the commissioner requests for the purpose of preparing the report required under section 12 of this act.

(b) The office, in consultation with the advisory council, may:

(1) Engage the services of such third-party actuaries, professionals and specialists that the executive director, in the executive director's discretion, deems necessary to assist the office in performing its duties under subsection (a) of this section;

(2) Designate centers of excellence to encourage utilization of hospitals and health care providers that produce the highest quality patient outcomes for designated services; and

(3) Seek an innovation waiver from the United States Department of the Treasury or the United States Department of Health and Human Services, as applicable, on behalf of this state pursuant to Section 1332 of the Affordable Care Act for any aspect of the Connecticut Option that the executive director determines, in the executive director's discretion, should not be implemented until this state receives such waiver.

Sec. 3. (NEW) (*Effective July 1, 2019*) (a) (1) There is established the Connecticut Option Advisory Council, which shall be convened by the office and advise the office on matters concerning the Connecticut Option. The council shall consist of the following seventeen members:

(A) The Comptroller, or the Comptroller's designee;

(B) The Secretary of the Office of Policy and Management, or the secretary's designee;

(C) The Insurance Commissioner, or the commissioner's designee;

(D) The Commissioner of Social Services, or the commissioner's designee;

(E) The chief executive officer of the exchange, or the chief executive officer's designee;

(F) The Healthcare Advocate, or the Healthcare Advocate's designee;

(G) The executive director;

(H) One appointed by the speaker of the House of Representatives, who shall be an expert in the field of health care economics;

(I) One appointed by the president pro tempore of the Senate, who shall be an expert in the field of health policy;

(J) One appointed by the minority leader of the House of Representatives, who shall be a representative of a patient advocacy organization;

(K) One appointed by the minority leader of the Senate, who shall be a representative of a small employer in this state;

(L) One appointed by the majority leader of the House of Representatives, who shall be a representative of individuals insured in the individual health insurance market in this state;

(M) One appointed by the majority leader of the Senate, who shall be a health benefits administrator for a large employer in this state; and

(N) Four appointed by the executive director, one of whom shall have skill, knowledge and expertise in offering health benefit plans in the individual market, one of whom shall have skill, knowledge and expertise in offering health benefit plans in the small employer market, one of whom shall be a representative of a hospital or hospital system, and one of whom shall be a representative of a nonhospital-based physician.

(2) The executive director shall serve as the chairperson of the advisory council.

(b) Initial appointments to the advisory council pursuant to subparagraphs (H) to (N), inclusive, of subdivision (1) of subsection (a) of this section shall be made on or before October 1, 2019. If an appointing authority fails to appoint an advisory council member pursuant to subparagraph (H), (I), (J), (K), (L), (M) or (N) of subdivision (1) of subsection (a) of this section 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 nine 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 of a member appointed pursuant to subparagraph (H), (I), (J), (K), (L), (M) or (N) of subdivision (1) of subsection (a) of this section 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 appointed pursuant to subparagraph (H), (I), (J), (K), (L), (M) or (N) of subdivision (1) of subsection (a) of this section shall serve for a term of five years or until a successor advisory council member is appointed, whichever is later. Each member of the advisory council appointed pursuant to subparagraph (H), (I), (J), (K), (L), (M) or (N) of subdivision (1) of subsection (a) of this section shall be eligible for reappointment. Any member of the advisory council appointed pursuant to subparagraph (H), (I), (J), (K), (L), (M) or (N) of subdivision (1) of subsection (a) of this section may be removed by the appropriate appointing authority for misfeasance, malfeasance or wilful neglect of duty.

(c) (1) No voting advisory council member shall, while such member is serving on the advisory council, be employed by, a consultant to, a member of the board of directors of, affiliated with or otherwise a representative of:

(A) An insurer;

(B) An insurance producer or broker;

(C) A health care provider;

(D) A health care facility or health or medical clinic; or

(E) A trade or business association representing an insurer, insurance producer, insurance broker, health care provider, health care facility, health clinic or medical clinic.

(2) For the purposes of this subsection, "health care provider" means any person that is licensed in this state, or operates or owns a facility or institution in this state, to provide health care or health care professional services in this state, or an officer, employee or agent thereof acting in the course and scope of such officer's, employee's or

agent's employment.

(d) The advisory council shall not be construed to be:

(1) A department, institution or agency of this state; or

(2) A board or commission within the meaning of section 4-9a of the general statutes.

Sec. 4. (NEW) (*Effective July 1, 2019*) (a) Not later than December 1, 2021, and annually thereafter, the executive director, in consultation with the advisory council, shall submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health.

(b) Each report submitted pursuant to subsection (a) of this section shall include:

(1) An evaluation of the individual and small employer health insurance markets in this state; and

(2) Recommended statutory, regulatory or other policy changes that would, if adopted or implemented, reduce health insurance premiums, out-of-pocket expenses and other costs without compromising the quality of health care in this state.

(c) Each annual report submitted pursuant to subsection (a) of this section after December 1, 2021, shall include:

(1) The items described in subsection (b) of this section; and

(2) The results of a study concerning opportunities to reduce the cost of health coverage for individuals and small employers in this state through other forms of government-sponsored health coverage, including, but not limited to, coverage that would allow small employers to purchase health coverage through a risk-pooled health insurance plan offered by the Comptroller, as well as:

(A) The cost of such coverage in comparison to health coverage available in the private market;

(B) The potential financial risks that may be incurred by this state in providing such coverage; and

(C) The impact that any loss of this state's exemption under the Employee Retirement Income Security Act of 1974, as amended from time to time, in providing such coverage would have on this state.

(d) The executive director shall submit a copy of each report required under this section to the Office of Policy and Management.

Sec. 5. (NEW) (*Effective July 1, 2019*) (a) For the purposes of this section:

(1) "Connecticut Option" has the same meaning as provided in section 1 of this act;

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

(3) "Health benefit plan" has the same meaning as provided in section 38a-1080 of the general statutes, as amended by this act;

(4) "Health carrier" has the same meaning as provided in section 38a-1080 of the general statutes, as amended by this act; and

(5) "Qualified health plan" has the same meaning as provided in section 38a-1080 of the general statutes, as amended by this act.

(b) The Comptroller shall develop a provider network that meets the requirements of the Connecticut Option. In developing such provider network, the Comptroller shall determine preferred providers and establish provider contracts that encourage improved health outcomes, care coordination and chronic disease management. The Comptroller shall, through a request for proposals, make such provider network available to one or more health carriers offering one

or more health benefit plans that meet the requirements of the Connecticut Option. Each proposer may contest, pursuant to section 4e-36 of the general statutes, the solicitation or award of a contract to one or more health carriers.

(c) Each health carrier selected by the Comptroller that makes the health benefit plans described in subsection (b) of this section available in the individual health insurance market shall offer at least one such plan off of the exchange, and apply to offer at least one such plan through the exchange as a qualified health plan in such market.

(d) Each health benefit plan offered pursuant to this section shall be fully insured and subject to regulation by the Insurance Department.

Sec. 6. (NEW) (*Effective July 1, 2019*) (a) For the purposes of this section:

(1) "Advisory council" means the Connecticut Option Advisory Council established under section 3 of this act;

(2) "Benchmark premium savings target" has the same meaning as provided in section 1 of this act; and

(3) "Connecticut Option" has the same meaning as provided in section 1 of this act.

(b) The Insurance Commissioner, in consultation with the advisory council, may adjust the benchmark premium savings target for health benefit plans comprising part of the Connecticut Option for each plan year beginning on or after January 1, 2023.

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

Sec. 7. Section 38a-1080 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

For purposes of sections 38a-1080 to 38a-1093, inclusive, as amended by this act, and sections 8 to 10, inclusive, of this act:

(1) "Board" means the board of directors of the Connecticut Health Insurance Exchange;

(2) "Commissioner" means the Insurance Commissioner;

(3) "Exchange" means the Connecticut Health Insurance Exchange established pursuant to section 38a-1081;

(4) "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;

(5) (A) "Health benefit plan" means an insurance policy or contract offered, delivered, issued for delivery, renewed, amended or continued in the state by a health carrier to provide, deliver, pay for or reimburse any of the costs of health care services.

(B) "Health benefit plan" does not include:

(i) Coverage of the type specified in subdivisions (5), (6), (7), (8), (9), (14), (15) and (16) of section 38a-469 or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation insurance;

(v) Automobile medical payment insurance;

(vi) Credit insurance;

(vii) Coverage for on-site medical clinics; or

(viii) Other similar insurance coverage specified in regulations

issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, under which benefits for health care services are secondary or incidental to other insurance benefits.

(C) "Health benefit plan" does not include the following benefits if they are provided under a separate insurance policy, certificate or contract or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits;

(ii) Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof; or

(iii) Other similar, limited benefits specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time;

(iv) Other supplemental coverage, similar to coverage of the type specified in subdivisions (9) and (14) of section 38a-469, provided under a group health plan.

(D) "Health benefit plan" does not include coverage of the type specified in subdivisions (3) and (13) of section 38a-469 or other fixed indemnity insurance if (i) such coverage is provided under a separate insurance policy, certificate or contract, (ii) there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and (iii) the benefits are paid with respect to an event without regard to whether benefits were also provided under any group health plan maintained by the same plan sponsor;

(6) "Health care services" has the same meaning as provided in section 38a-478;

(7) "Health carrier" means an insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity subject to the insurance laws and

regulations of the state or the jurisdiction of the commissioner that contracts or offers to contract to provide, deliver, pay for or reimburse any of the costs of health care services;

(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) "Person" has the same meaning as provided in section 38a-1;

(10) "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with subsection (e) of section 38a-1086;

(11) "Qualified employer" has the same meaning as provided in Section 1312 of the Affordable Care Act;

(12) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in Section 1311(c) of the Affordable Care Act and section 38a-1086;

(13) "Qualified individual" has the same meaning as provided in Section 1312 of the Affordable Care Act;

(14) "Secretary" means the Secretary of the United States Department of Health and Human Services; and

(15) "Small employer" has the same meaning as provided in section 38a-564.

Sec. 8. (NEW) (*Effective July 1, 2019*) (a) For the purposes of this section, "Connecticut Option" has the same meaning as provided in section 1 of this act.

(b) Except as provided in subsection (c) of this section, each health carrier that offers a qualified health plan through the exchange for any plan year beginning on or after January 1, 2022, shall:

(1) If such qualified health plan is offered in the individual health

insurance market, apply to offer through the exchange in such market and for such plan year at least one qualified health plan as part of the Connecticut Option; or

(2) If such qualified health plan is offered in the small employer health insurance market, apply to offer through the exchange in such market and for such plan year at least one qualified health plan as part of the Connecticut Option.

(c) No health carrier that is required to apply to offer a qualified health plan pursuant to subsection (b) of this section shall offer such plan unless such plan has been approved by the Insurance Commissioner.

Sec. 9. (NEW) (*Effective July 1, 2019*) There is established a fund to be known as the "Connecticut Health Insurance Subsidies Fund", which shall contain any moneys required by law to be deposited in the fund. The moneys within the fund shall be used to provide funding for state-financed health insurance premium and cost-sharing subsidies for individuals in this state. The fund shall be administered by the subsidiary established by the exchange pursuant to section 10 of this act, and accounted for separately from all other moneys, funds and accounts administered by the exchange.

Sec. 10. (NEW) (*Effective July 1, 2019*) The exchange shall establish a subsidiary pursuant to section 38a-1093 of the general statutes. Such subsidiary shall establish eligibility criteria for state level premium and cost-sharing subsidies, administer the fund established under section 9 of this act and use the moneys within such fund to provide such subsidies.

Sec. 11. (NEW) (*Effective July 1, 2019*) (a) For the purposes of this section:

(1) "Connecticut Option" has the same meaning as provided in section 1 of this act;

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

(3) "Qualified health plan" has the same meaning as provided in section 38a-1080 of the general statutes, as amended by this act.

(b) Except as provided in subsection (c) of this section, each contract authorized under subdivision (2) of subsection (m) of section 5-259 of the general statutes may require that each third-party administrator that is both a party to such contract and a health carrier authorized to do health insurance business in this state apply to offer, for each plan year beginning on or after July 1, 2020, and during the term of such contract, the following qualified health plans through the exchange:

(1) At least one qualified health plan providing coverage in the individual health insurance market; and

(2) At least one qualified health plan providing coverage in the small employer health insurance market.

(c) No third-party administrator shall be required to apply to offer a qualified health plan pursuant to subsection (b) of this section if:

(1) Such third-party administrator enters into a contract with the Comptroller exclusively to provide a dental or other nonmedical plan in connection with, or in addition to, the self-insured plans described in subdivision (1) of subsection (m) of section 5-259 of the general statutes;

(2) Such qualified health plan has not been approved by the Insurance Commissioner;

(3) Such third-party administrator entered into the contract described in subsection (b) of this section on or before July 1, 2019; or

(4) Such third-party administrator is unable to offer such qualified health plan because such third-party administrator may not issue such qualified health plan during the five-year period described in 42 CFR

148.122(f).

Sec. 12. (NEW) (*Effective July 1, 2019*) (a) The Insurance Commissioner shall issue guidance to allow for the use of centers of excellence within networks offered through the Connecticut Option, as defined in section 1 of this act.

(b) (1) Beginning in 2022, the Insurance Commissioner shall, not less than annually, submit a report to the Office of Health Strategy established under section 19a-754a of the general statutes, as amended by this act, the Connecticut Option Advisory Council established under section 3 of this act, the Office of Policy and Management and the Office of Fiscal Analysis concerning the health benefit plans comprising the Connecticut Option, as defined in section 1 of this act. Such report shall include, but need not be limited to, the cost savings and access achieved by such health benefit plans for the immediately preceding plan year.

(2) The Office of Health Strategy shall review such report, in conjunction with the reports submitted pursuant to section 4 of this act, to determine the factors that contributed to the cost savings and access described in subdivision (1) of this subsection and what further actions may be taken to assist the health benefit plans comprising the Connecticut Option to achieve further cost savings and improved access.

Sec. 13. Section 12-1 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

The following words, as used in this title<u>, sections 14 to 18, inclusive, of this act</u> and in all other statutes relating to the assessment and collection of taxes, except when otherwise indicated by the context, shall be defined as follows: "Commissioner" or "Commissioner of Revenue Services" means the Commissioner of Revenue Services or his authorized agent; "company" means any person, partnership, association, company, limited liability company or corporation, except an incorporated municipality; "person" means any individual,

partnership, company, limited liability company, public or private corporation, society, association, trustee, executor, administrator or other fiduciary or custodian.

Sec. 14. (NEW) (*Effective January 1, 2022, and applicable to taxable years commencing on or after January 1, 2022*) For the purposes of this section and sections 15 to 18, inclusive, of this act, unless the context otherwise requires:

(1) "Adjusted gross income" has the same meaning as provided 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 entity" means: (A) An employer or other sponsor of an employment-based health plan with respect to employment-based minimum essential coverage; (B) the Department of Social Services with respect to the Medicaid state plan or the state children's health insurance plan; and (C) a health carrier with respect to coverage provided by such health carrier, other than coverage described in subparagraph (A) or (B) of this subdivision.

(5) "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 incarcerated, unless such individual is incarcerated pending the disposition of charges; and (C) 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.

(6) "Connecticut adjusted gross income" has the same meaning as provided in section 12-701 of the general statutes.

(7) "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.

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

(9) "Eligible employer-sponsored plan" has the same meaning as provided in Section 5000A of the Internal Revenue Code, as in effect on December 15, 2017.

(10) "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, notwithstanding that the amount of such allowed deduction may be zero.

(11) "Health carrier" has the same meaning as provided in section 38a-1080 of the general statutes, as amended by this act.

(12) "Household income" means, with respect to a taxpayer for a taxable year, the taxpayer's Connecticut adjusted gross income for the taxable year plus the Connecticut 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,

notwithstanding that the amount of such allowed deduction may be zero; and (B) who were required to file a return pursuant to chapter 229 of the general statutes 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 chapter 229 of the general statutes for a taxable year.

(15) "Minimum essential coverage" means minimum essential coverage within the meaning of Section 5000A of the Internal Revenue Code, as said section was in effect on December 15, 2017, together with such additional coverage that the Office of Health Strategy may prescribe in regulations adopted pursuant to section 19 of this act.

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

(17) "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.

(18) "Taxpayer" means a resident of this state who is a taxpayer within the meaning of Section 5000A of the Internal Revenue Code, as in effect on December 15, 2017.

Sec. 15. (NEW) (*Effective January 1, 2022, and applicable to taxable years commencing on or after January 1, 2022*) (a) (1) Each taxpayer shall, for each month beginning on or after January 1, 2022, 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 or portion thereof during which the applicable individual is not a resident of this state if:

(A) Such month or portion thereof 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 portion thereof; or

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

(b) (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 (a) 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 (c) of this section.

(B) If an applicable individual fails to maintain minimum essential coverage for any month or portion thereof beginning on or after January 1, 2022, and a taxpayer claims such applicable individual as a dependent for the taxable year that includes such month or portion thereof, 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 or portion thereof beginning on or after January 1, 2022, 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 for an applicable individual for a month for which the applicable individual is:

(A) Eligible for an exemption under Section 5000A(e) of the Internal Revenue Code, as in effect on December 15, 2017; or

(B) Not required to file a return on personal income under chapter 229 of the general statutes.

(c) (1) Except as reduced by subdivision (3) of this subsection, if applicable, the amount of the fee imposed under subsection (b) 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; or

(B) The annual premium for the lowest-cost qualified health plan offered through the exchange (i) that provides a bronze 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.

(2) For the purposes of subparagraph (A) of subdivision (1) of this subsection, the monthly fee amount for a taxpayer for any month or portion thereof during which a failure described in subsection (a) 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 for whom the taxpayer is liable 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 older than is eighteen years of age 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 the exemption set forth in section 12-702 of the general statutes with respect to the taxpayer for the taxable year.

(3) If a taxpayer is subject to the fee imposed under subsection (b) 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.

(d) (1) A taxpayer who incurs a fee under subsection (b) of this section for any month or portion thereof shall report the fee and submit payment for such fee to the commissioner, in a form and manner prescribed by the commissioner, on or before the due date of the taxpayer's income tax return for the taxable year that includes such month, as required pursuant to chapter 229 of the general statutes.

(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 (b) of this section, and such fee may not be collected as a tax under the provisions of section 12-35 of the general statutes.

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

(4) The commissioner shall deposit all payments received under

subdivision (1) of this subsection in the fund established under section 9 of this act.

Sec. 16. (NEW) (*Effective January 1, 2022, and applicable to taxable years commencing on or after January 1, 2022*) (a) (1) Each applicable entity that provides minimum essential coverage to one or more individuals in this state shall submit an annual return to the commissioner, on or before January 1, 2023, and annually thereafter, for the purpose of assisting the commissioner in collecting the fee imposed under subsection (b) of section 15 of this act. Such return shall:

(A) Be filed in a form and manner prescribed by the commissioner; and

(B) Except as provided in subdivision (2) of this subsection, contain the following information for the calendar year that is the subject of such return:

(i) The name, address and taxpayer identification number of each individual that such applicable entity covered during such year;

(ii) The dates during which such applicable entity provided coverage to each individual described in clause (i) of this subparagraph during such year; and

(iii) Such other information that the commissioner, in the commissioner's discretion, may prescribe to carry out the purpose of this section.

(2) Each return that contains the information, and is in the form, of a return described in Section 6055 of the Internal Revenue Code, as in effect on December 15, 2017, shall be deemed to satisfy the provisions of subdivision (1) of this subsection.

(b) (1) (A) Except as provided in subdivision (2) of this subsection, each applicable entity that is required to submit a return pursuant to subsection (a) of this section shall send to each individual included in such return a written statement disclosing:

(i) Such applicable entity's name, address and telephone number; and

(ii) All information included in such return concerning such individual.

(B) Each applicable entity that is required to send a written statement pursuant to subparagraph (A) of this subdivision shall send such statement not later than January thirty-first of the year following the calendar year that is the subject of the corresponding return.

(2) Each applicable entity that sends a written statement to an individual that contains the information, and is in the form, of a written statement described in Section 6055 of the Internal Revenue Code, as in effect on December 15, 2017, shall be deemed to have satisfied the provisions of subdivision (1) of this subsection with respect to such individual.

(c) If an applicable entity is a government agency, unit or instrumentality thereof, the officer or employee of such agency, unit or instrumentality who entered into an agreement to provide minimum essential coverage shall be responsible for filing the return required under subsection (a) of this section and sending the written statements required under subsection (b) of this section.

(d) Notwithstanding any provision of this section, an applicable entity may contract with a third-party service provider, including, but not limited to, a health carrier, to file the returns required under subsection (a) of this section and send the written statements required under subsection (b) of this section.

Sec. 17. (NEW) (*Effective January 1, 2022, and applicable to taxable years commencing on or after January 1, 2022*) During the period beginning on November first and ending on November thirtieth, annually, the Commissioner of Revenue Services, in consultation with the Insurance Commissioner, the executive director of the Office of Health Strategy established under section 19a-754a of the general statutes, as amended

by this act, and the Connecticut Health Insurance Exchange established under section 38a-1081 of the general statutes, shall send a notice to each taxpayer who files a return for the personal income tax imposed under chapter 229 of the general statutes for a taxable year commencing on or after January 1, 2022, and is not, or claims a dependent who is not, enrolled in minimum essential coverage. Such notice shall disclose that such taxpayer or dependent is not enrolled in such coverage, and include information concerning the services available through the exchange.

Sec. 18. (NEW) (*Effective January 1, 2022*) Except as provided in subdivision (15) of section 14 of this act, the commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of sections 14 to 17, inclusive, of this act.

Sec. 19. (NEW) (*Effective January 1, 2022, and applicable to taxable years commencing on or after January 1, 2022*) The Office of Health Strategy established under section 19a-754a of the general statutes, as amended by this act, in consultation with the Insurance Commissioner and the chief executive officer of the Connecticut Health Insurance Exchange established under section 38a-1081 of the general statutes, may adopt regulations, in accordance with chapter 54 of the general statutes, prescribing which coverage, in addition to minimum essential coverage within the meaning of Section 5000A of the Internal Revenue Code of 1986, as said section was in effect on December 15, 2017, constitutes minimum essential coverage for the purposes of subdivision (15) of section 14 of this act. The Office of Health Strategy may enter into contracts with actuarial, economic or other experts and consultants to assist the office in carrying out the purposes of this section.

Sec. 20. Section 38a-1084 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

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) 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 and the fee imposed under subsection (b) of section 15 of this act, an individual is exempt from the individual responsibility **[**requirement**]** requirements or from the penalty imposed by said Section 5000A or fee imposed under subsection (b) of section 15 of this act because:

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

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

(C) The individual has certified that such individual is:

(i) A member, and adherent to the established tenets or teachings, of a recognized religious sect or division thereof described in Section 1402(g)(1) of the Internal Revenue Code, as amended from time to time; or

(ii) A member of a religious sect or division thereof that is not described in Section 1402(g)(1) of the Internal Revenue Code, as amended from time to time, relies solely on a religious method of healing and for whom the acceptance of medical health services would be inconsistent with such individual's religious beliefs.

(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 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; and

(B) Provide to the Commissioner of Revenue Services the information described in subparagraphs (A)(i) to (A)(iii), inclusive, of this subdivision;

(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 and the provisions of sections 14 to 19, inclusive, of this act 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, as amended by

this act, 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, as amended by this act, 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.

Sec. 21. Section 19a-754a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) There is established an Office of Health Strategy, which shall be within the Department of Public Health for administrative purposes only. The department head of said office shall be the executive director of the Office of Health Strategy, who shall be appointed by the Governor in accordance with the provisions of sections 4-5 to 4-8, inclusive, with the powers and duties therein prescribed.

(b) The Office of Health Strategy shall be responsible for the following:

(1) Developing and implementing a comprehensive and cohesive health care vision for the state, including, but not limited to, a coordinated state health care cost containment strategy;

(2) Promoting effective health planning and the provision of quality health care in the state in a manner that ensures access for all state residents to cost-effective health care services, avoids the duplication of such services and improves the availability and financial stability of such services throughout the state;

(3) (A) Directing and overseeing innovative health care delivery and payment models in the state that reduce health care cost growth and improve the quality of patient care, including, but not limited to, the State Innovation Model Initiative and related successor initiatives, (B) setting a health care cost growth benchmark, as defined in section 22 of this act, for the state across all payers and populations, (C) enhancing the transparency of provider organizations in the state, (D) monitoring the development of accountable care organizations and patient-centered medical homes in the state, and (E) monitoring the adoption of alternative payment methodologies in the state;

(4) (A) Coordinating the state's health information technology initiatives, (B) seeking funding for and overseeing the planning, implementation and development of policies and procedures for the administration of the all-payer claims database program established under section 19a-775a, (C) establishing and maintaining a consumer health information Internet web site under 19a-755b, and (D) designating an unclassified individual from the office to perform the duties of a health information technology officer as set forth in sections 17b-59f and 17b-59g;

(5) Directing and overseeing the Health Systems Planning Unit established under section 19a-612 and all of its duties and responsibilities as set forth in chapter 368z; and

(6) Convening forums and meetings with state government and external stakeholders, including, but not limited to, the Connecticut Health Insurance Exchange, to discuss health care issues designed to develop effective health care cost and quality strategies.

(c) The Office of Health Strategy shall constitute a successor, in accordance with the provisions of sections 4-38d, 4-38e and 4-39, to the functions, powers and duties of the following:

(1) The Connecticut Health Insurance Exchange, established pursuant to section 38a-1081, relating to the administration of the all-payer claims database pursuant to section 19a-755a; and

(2) The Office of the Lieutenant Governor, relating to the (A) development of a chronic disease plan pursuant to section 19a-6q, (B) housing, chairing and staffing of the Health Care Cabinet pursuant to section 19a-725, and (C) (i) appointment of the health information technology officer, and (ii) oversight of the duties of such health information technology officer as set forth in sections 17b-59f and 17b-59g.

(d) Any order or regulation of the entities listed in subdivisions (1) and (2) of subsection (c) of this section that is in force on July 1, 2018, shall continue in force and effect as an order or regulation until amended, repealed or superseded pursuant to law.

Sec. 22. (NEW) (*Effective July 1, 2019*) For the purposes of this section and sections 23 to 29, inclusive, of this act:

(1) "Device manufacturer" means a manufacturer that manufactures a device for which annual sales attributable to residents of this state exceed ten million dollars;

(2) "Drug manufacturer" means the manufacturer of a drug that is: (A) Reported by a health carrier pursuant to section 38a-479qqq of the general statutes; (B) studied or listed pursuant to subsection (c) or (d) of section 19a-754b of the general statutes; or (C) in a therapeutic class

of drugs that the office determines, through public or private reports, has had a substantial impact on prescription drug expenditures, net of rebates, as a percentage of total health care expenditures;

(3) "Executive director" means the executive director of the office;

(4) "Health care cost growth benchmark" means the annual benchmark established pursuant to section 23 of this act;

(5) "Health care entity" means an accountable care organization, ambulatory surgical center, clinic, hospital or physician organization in this state, other than a physician contracting unit that, for a given calendar year: (A) Has a patient panel of not more than five thousand patients; or (B) represents providers who collectively receive less than ten million dollars in net patient service revenue from health carriers;

(6) "Health status adjusted total medical expenses" means: (A) The total cost of care for the patient population of a group of health care providers with at least thirty-six thousand member months for a given calendar year, which cost (i) is calculated for such year on the basis of the allowed claims for all categories of medical expenses and all nonclaims payments for such year, including, but not limited to, cost-sharing payments, adjusted by health status and expressed on a per member, per month basis for all members in this state who are required to select a primary care physician for such year, (ii) is reported separately for Medicaid, Medicare and nongovernment health plans for such year, and (iii) discloses the health adjustment risk score and the version of the risk adjustment tool used to calculate such score for such group for such year; and (B) the total aggregate medical expenses for all physicians and physician groups with fewer than thirty-six thousand member months for a given calendar year;

(7) "Office" means the Office of Health Strategy established under section 19a-754a of the general statutes, as amended by this act;

(8) "Other entity" means a device manufacturer, drug manufacturer or pharmacy benefits manager;

(9) "Payer" means a payer that, during a given calendar year, pays providers for health care services on behalf of, or pharmacies for prescription drugs dispensed to, more than ten thousand individuals in this state;

(10) "Pharmacy benefits manager" has the same meaning as provided in section 38a-479ooo of the general statutes;

(11) "Total health care expenditures" means the per capita sum of all health care expenditures in this state from public and private sources for a given calendar year, including: (A) All categories of medical expenses and all nonclaims-related payments to health care providers, as included in the health status adjusted total medical expenses reported by the office pursuant to subsection (c) of section 25 of this act; (B) all patient cost-sharing amounts, including, but not limited to, deductibles and copayments; (C) the net cost of nongovernment health insurance; (D) prescription drug expenditures net of rebates and discounts; (E) device manufacturer expenditures net of rebates and discounts; and (F) any other expenditures specified by the executive director;

(12) "Total medical expenses" means the sum, for a given calendar year, of medical claims and total nonclaims payments for: (A) Each physician and physician group with at least thirty-six thousand member months, and serving members in this state required to select a primary care physician, for such year; and (B) medical claims and total nonclaims payments for all physicians or physician groups with fewer than thirty-six thousand member months for such year; and

(13) "Total nonclaims payments" means the sum of all nonclaims payments for a given calendar year, aggregated for the following categories: (A) Incentive programs; (B) risk settlements; (C) care management expenses; and (D) other.

Sec. 23. (NEW) (*Effective July 1, 2019*) (a) Not later than October 1, 2020, and annually thereafter, the office shall establish a health care cost growth benchmark for the calendar year next succeeding. Such

benchmark shall address the average growth in health care expenditures across all payers and populations in this state for such year.

(b) In establishing each health care cost growth benchmark pursuant to subsection (a) of this section, the office shall, at a minimum:

(1) Consider any change in the consumer price index for all urban consumers in the northeast region from the preceding calendar year, and the most recent publicly available information concerning the growth rate of the gross state product; and

(2) (A) Hold an informational public hearing concerning such benchmark:

(i) At a time and place designated by the executive director in a notice prominently posted on the office's Internet web site;

(ii) In a form and manner prescribed by the executive director; and

(iii) On the basis of the most recent report prepared by the office pursuant to subsection (c) of section 25 of this act and any other information that the executive director, in the executive director's discretion, deems relevant for the purposes of such hearing.

(B) Notwithstanding subparagraph (A) of this subdivision, the office shall not be required to hold an informational public hearing concerning a health care cost growth benchmark for any calendar year beginning on or after January 1, 2022, if such benchmark is the same as the benchmark for the preceding calendar year.

(c) If the executive director determines, after any public hearing held pursuant to subdivision (2) of subsection (b) of this section, that a modification to the health care cost growth benchmark is, in such executive director's discretion, reasonably warranted, the office may modify such benchmark.

(d) The executive director shall cause each health care cost growth

benchmark to be posted on the office's Internet web site.

(e) The office may enter into such contractual agreements as may be necessary to carry out the purposes of this section, including, but not limited to, contractual agreements with actuarial, economic and other experts and consultants to assist the office in establishing health care cost growth benchmarks.

Sec. 24. (NEW) (*Effective July 1, 2019*) (a) (1) Not later than May 1, 2022, and annually thereafter, the office shall hold a public hearing to compare the growth in total health care expenditures during the preceding calendar year to the health care cost growth benchmark established pursuant to section 23 of this act for such year. Each hearing shall involve an examination of:

(A) The report most recently prepared by the office pursuant to subsection (c) of section 25 of this act;

(B) The expenditures of health care entities, including, but not limited to, health care cost trends and the factors contributing to such costs;

(C) Whether one category of expenditures may be offset by savings in another category; and

(D) Any other matters that the executive director, in the executive director's discretion, deems relevant for the purposes of this section.

(2) The executive director may require that any health care entity that is found to be a significant contributor to health care cost growth in this state during the preceding calendar year participate in the public hearing. Each such health care entity that is required to participate in such public hearing shall provide testimony on issues identified by the executive director, and provide additional information on actions taken to reduce such health care entity's contribution to future state-wide health care costs.

(b) Not later than October 1, 2022, and annually thereafter, the office

shall prepare and submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health. Such report shall:

(1) Be based on the office's analysis of the information submitted during the most recent public hearing conducted pursuant to subsection (a) of this section and any other information that the executive director, in the executive director's discretion, deems relevant for the purposes of this section;

(2) Describe health care spending trends in this state and the factors underlying such trends; and

(3) Disclose the office's recommendations, if any, concerning strategies to increase the efficiency of this state's health care system, including, but not limited to, any recommended legislation concerning this state's health care system.

Sec. 25. (NEW) (*Effective July 1, 2019*) (a) Not later than March 1, 2021, and annually thereafter, each institutional provider, on behalf of such institutional provider and its parent organization and affiliated entities, noninstitutional provider and provider organization in this state shall submit to the office, for the preceding calendar year:

(1) Data, submitted separately for patients covered under health benefit plans comprising part of the Connecticut Option, as defined in section 1 of this act, and patients not covered under such plans, concerning:

(A) The utilization of health care services provided by such provider or organization;

(B) The charges, prices imposed and payments received by such provider or organization for such services;

(C) The costs incurred, and revenues earned, by such provider or organization in providing such services; and

(D) Any other matter that the executive director deems relevant for the purposes of this section; and

(2) If such provider is a hospital, the data described in subdivision (1) of this subsection and such additional data, information and documents designated by the executive director, including, but not limited to, charge masters, cost data, audited financial statements and merged billing and discharge data, provided such provider shall not be required to submit any data contained in a report that is filed pursuant to chapters 368aa to 368*ll*, inclusive, of the general statutes and available to the executive director.

(b) The executive director shall establish standards to ensure that the data, information and documents submitted to the office pursuant to subsection (a) of this section are submitted to the office in a uniform manner. Such standards shall enable the executive director to identify, on a patient-centered and provider-specific basis, state-wide and regional trends in the availability, cost, price and utilization of medical, surgical, diagnostic and ancillary services provided by acute care hospitals, chronic disease hospitals, rehabilitation hospitals and other specialty hospitals, clinics, including, but not limited to, psychiatric clinics, and facilities providing ambulatory care. Such standards may require hospitals to submit such data, information and documents to the office in an electronic form, provided such standards shall provide for a waiver of such requirement if such waiver is reasonable in the judgment of the executive director.

(c) (1) Not later than December 1, 2021, and annually thereafter, the office shall prepare, and the executive director shall cause to be posted on the office's Internet web site, a report concerning health status adjusted total medical expenses for the preceding calendar year, including, but not limited to:

(A) A breakdown of such health status adjusted total medical expenses by:

(i) Major service category;

(ii) Payment methodology;

(iii) Relative price;

(iv) Direct hospital inpatient cost;

(v) Indirect hospital inpatient cost;

(vi) Direct hospital outpatient cost; and

(vii) Indirect hospital outpatient cost; and

(B) An analysis and evaluation of the impact of the Connecticut Option, as defined in section 1 of this act, on total medical expenses.

(2) Notwithstanding subdivision (1) of this subsection, the office shall not disclose any provider specific data or information unless the executive director provides at least ten days' advance written notice of such disclosure to each provider that would be affected by such disclosure.

(d) The executive director shall, at least annually, submit a request to the federal Centers for Medicare and Medicaid Services for the health status adjusted total medical expenses of provider groups that served Medicare patients during the calendar year next preceding.

(e) The office may enter into such contractual agreements as may be necessary to carry out the purposes of this section, including, but not limited to, contractual agreements with actuarial, economic and other experts and consultants.

Sec. 26. (NEW) (*Effective July 1, 2019*) (a) (1) For each calendar year beginning on or after January 1, 2022, if the executive director determines that the average annual percentage change in total health care expenditures for the preceding calendar year exceeded the health care cost growth benchmark for such year, the executive director shall identify, not later than April first of such calendar year, each health care entity or payer that exceeded such benchmark for such year.

(2) The executive director may require that any health care entity that is found to be a significant contributor to health care cost growth in this state during the preceding calendar year participate in the public hearing. Each such health care entity that is required to participate in such public hearing shall provide testimony on issues identified by the executive director, and provide additional information on actions taken to reduce such health care entity's contribution to future state-wide health care costs.

(b) Not later than thirty days after the executive director identifies each health care entity or payer pursuant to subsection (a) of this section, the executive director shall send a notice to each such entity or payer. Such notice shall be in a form and manner prescribed by the executive director, and disclose to each such entity or payer, at a minimum:

(1) That the executive director has identified such entity or payer pursuant to subsection (a) of this section;

(2) The factual basis for the executive director's identification of such entity or payer pursuant to subsection (a) of this section; and

(3) That such entity or payer shall file a proposed performance improvement plan pursuant to subdivision (1) of subsection (e) of this section, provided such entity or payer may:

(A) File a request for an extension of time, or a waiver, pursuant to subdivision (1) of subsection (c) of this section; and

(B) Request a hearing pursuant to subsection (d) of this section.

(c) (1) (A) Each health care entity or payer identified by the executive director pursuant to subsection (a) of this section may, not later than thirty days after the executive director sends a notice to such entity or payer pursuant to subsection (b) of this section, file with the office, in a form and manner prescribed by the executive director, a request seeking:

(i) An extension of time to file a proposed performance improvement plan pursuant to subdivision (1) of subsection (e) of this section; or

(ii) A waiver from the requirement that such entity or payer file a proposed performance improvement plan pursuant to subdivision (1) of subsection (e) of this section.

(B) Each health care entity or payer that files a request pursuant to subparagraph (A) of this subdivision shall set forth the reasons for such request in such request.

(2) Not later than thirty days after a health care entity, payer or other entity files a request pursuant to subdivision (1) of this subsection, the executive director shall:

(A) Examine the reasons set forth in the request and decide, on the basis of such reasons, whether to approve or deny such request; and

(B) Send a notice, in a form and manner prescribed by the executive director, to the entity or payer that filed such request disclosing, at a minimum:

(i) The executive director's decision concerning such request and the reasons therefor;

(ii) If the executive director denies such entity's or payer's request, that such entity or payer may file a request for a hearing pursuant to subsection (d) of this section; and

(iii) If such entity's or payer's request is a request for an extension of time to file a proposed performance improvement plan pursuant to subdivision (1) of subsection (e) of this section and the executive director approves such request, the date by which such entity or payer shall file such proposed plan.

(d) Each health care entity or payer identified by the executive director pursuant to subsection (a) of this section may, not later than

thirty days after the executive director sends a notice to such entity or payer pursuant to subsection (b) of this section or subparagraph (B) of subdivision (2) of subsection (c) of this section, as applicable, file with the office a request for a hearing. Each hearing conducted pursuant to this subsection shall be conducted in accordance with the procedures for hearings on contested cases established in chapter 54 of the general statutes.

(e) (1) Each health care entity or payer identified by the executive director pursuant to subsection (a) of this section, or required by the executive director pursuant to subparagraph (C)(ii)(III) of subdivision (4) of subsection (f) of this section, shall, subject to the provisions of subsections (b) to (d), inclusive, of this section, file with the office a proposed performance improvement plan. Such entity or payer shall file such proposed plan, which shall include an implementation timetable, with the office, in a form and manner prescribed by the executive director, not later than whichever of the following dates first occurs:

(A) The date that is thirty days after the date on which the executive director sent a notice to such entity or payer pursuant to subsection (b) of this section;

(B) The date that the executive director disclosed to such entity or payer pursuant to subparagraph (B)(iii) of subdivision (2) of subsection (c) of this section; or

(C) The date that is thirty days after the date on which the notice of a final decision is issued following a public hearing conducted pursuant to subsection (d) of this section.

(2) (A) The executive director shall review each health care entity's and payer's proposed performance improvement plan filed pursuant to subdivision (1) of this subsection to determine whether, in the executive director's judgment, it is reasonably likely that:

(i) Such proposed plan will address the cause of such entity's or

payer's excessive cost growth; and

(ii) Such entity or payer will successfully implement such proposed plan.

(B) After the executive director reviews a proposed performance improvement plan pursuant to subparagraph (A) of this subdivision, the executive director shall:

(i) Approve such proposed plan if the executive director determines, in the executive director's judgment, that such proposed plan satisfies the criteria established in subparagraph (A) of this subdivision; or

(ii) Deny such proposed plan if the executive director determines, in the executive director's judgment, that such proposed plan does not satisfy the criteria established in subparagraph (A) of this subdivision.

(C) (i) Not later than thirty days after the executive director approves or denies a proposed performance improvement plan pursuant to subparagraph (B) of this subdivision, the executive director shall send a notice to the health care entity, payer or other entity that filed such proposed plan disclosing, at a minimum that:

(I) The executive director approved such proposed plan; or

(II) The executive director denied such proposed plan, the reasons for such denial and that such entity or payer shall file with the office such amendments as are necessary for such proposed plan to satisfy the criteria established in subparagraph (A) of this subdivision.

(ii) The executive director shall cause a notice to be posted on the office's Internet web site disclosing:

(I) The name of each health care entity or payer that files, and receives approval for, a proposed performance improvement plan; and

(II) That such health care entity, payer or other entity is implementing such plan.

(D) Each health care entity or payer that receives a notice from the executive director pursuant to subparagraph (C)(i) of this subdivision notifying such entity or payer that the executive director has denied such entity's or payer's proposed performance improvement plan shall file with the office, in a form and manner prescribed by the executive director and not later than thirty days after the date that the executive director sends such notice to such entity or payer, such amendments as are necessary for such proposed plan to satisfy the criteria established in subparagraph (A) of this subdivision.

(f) (1) Each health care entity or payer that receives a notice from the executive director pursuant to subparagraph (C)(i) of subdivision (2) of subsection (e) of this section notifying such entity or payer that the executive director has approved such entity's or payer's proposed performance improvement plan:

(A) Shall immediately make good faith efforts to implement such plan; and

(B) May amend such plan at any time during the implementation timetable included in such plan, provided the executive director approves such amendment.

(2) The office shall provide such assistance to each health care entity or payer that the executive director, in the executive director's discretion, deems necessary and appropriate to ensure that such entity or payer successfully implements such entity's or payer's performance improvement plan.

(3) Each health care entity or payer shall be subject to such additional reporting requirements that the executive director, in the executive director's discretion, deems necessary to ensure that such entity or payer successfully implements such entity's or payer's performance improvement plan.

(4) (A) Each health care entity or payer that files, and receives approval for, a performance improvement plan pursuant to this

section shall, not later than thirty days after the last date specified in the implementation timetable included in such plan, submit to the office, in a form and manner prescribed by the executive director, a report regarding the outcome of such entity's or payer's implementation of such plan.

(B) If the executive director determines, on the basis of the report submitted by a health care entity or payer pursuant to subparagraph (A) of this subdivision, that such entity or payer successfully implemented such entity's or payer's performance improvement plan, the executive director shall:

(i) Send a notice to such entity or payer, in a form and manner prescribed by the executive director, disclosing such determination; and

(ii) Cause the notice posted on the office's Internet web site pursuant to subparagraph (C)(ii) of subdivision (2) of subsection (e) of this section concerning such entity or payer to be removed from such Internet web site.

(C) If the executive director determines, on the basis of the report submitted by a health care entity or payer pursuant to subparagraph (A) of this subdivision, that such entity or payer failed to successfully implement such entity's or payer's performance improvement plan, the executive director shall:

(i) Send a notice to such entity or payer, in a form and manner prescribed by the executive director, disclosing such determination and any action taken by the executive director pursuant to clause (ii) of this subparagraph; and

(ii) In the executive director's discretion:

(I) Extend the implementation timetable included in such plan;

(II) Require such entity or payer to file with the office, in a form and manner prescribed by the executive director, such amendments to such

plan as are, in the executive director's judgment, necessary to ensure that such entity or payer successfully implements such plan;

(III) Require such entity or payer to file a new proposed performance improvement plan pursuant to subdivision (1) of subsection (e) of this section; or

(IV) Waive or delay the requirement that such entity or payer file any future proposed performance improvement plan until the executive director determines, in the executive director's discretion, that such entity or payer has successfully implemented such plan.

(g) The office shall keep confidential all nonpublic clinical, financial, operational or strategic documents and information filed with, or submitted to, the office pursuant to this section. The office shall not disclose any such document or information to any person without the consent of the health care entity or payer that filed such document or information with, or submitted such document or information to, the office pursuant to this section, except in summary form as part of an evaluative report if the executive director determines, in the executive director's discretion, that disclosure of such document or information in such form is in the public interest notwithstanding any concerns regarding a breach of privacy or the disclosure of trade secrets or proprietary business information. Notwithstanding any provision of the general statutes, no document or information filed with, or submitted to, the office pursuant to this section shall be deemed to be a public record or subject to disclosure under the Freedom of Information Act, as defined in section 1-200 of the general statutes.

Sec. 27. (NEW) (*Effective July 1, 2019*) (a) (1) For each calendar year beginning on or after January 1, 2022, if the executive director determines that the average annual percentage change in total health care expenditures for the preceding calendar year exceeded the health care cost growth benchmark for such year, the executive director shall identify each other entity that significantly contributed to exceeding such benchmark. Each identification shall be based on:

(A) The report prepared pursuant to subsection (c) of section 25 of this act;

(B) The reports filed and submitted pursuant to section 38a-479ppp of the general statutes;

(C) The information and data reported to the office pursuant to section 19a-754b of the general statutes;

(D) Information obtained from the all-payer claims database established under section 19a-755a of the general statutes; and

(E) Any other information that the executive director, in the executive director's discretion, deems relevant for the purposes of this section.

(2) The executive director shall account for costs, net of rebates and discounts, when identifying other entities pursuant to this section.

(b) The executive director may require that any other entity that is found to be a significant contributor to health care cost growth in this state during the preceding calendar year participate in the public hearing held pursuant to subsection (a) of section 24 of this act. Each such other entity that is required to participate in such public hearing shall provide testimony on issues identified by the executive director, and provide additional information on actions taken to reduce such health care entity's contribution to future state-wide health care costs. If such other entity is a drug manufacturer, and the executive director requires that such drug manufacturer participate in such public hearing with respect to a specific drug or class of drugs, such public hearing may, to the extent possible, include representatives from at least one brand name manufacturer, one generic manufacturer and one innovator company that is less than ten years old.

Sec. 28. (NEW) (*Effective July 1, 2019*) (a) The executive director shall appoint a quality council, and shall ensure that the membership of such council includes individuals with experience providing health

care services, and coverage for such services, in this state.

(b) The quality council shall have the following duties:

(1) (A) To develop, in consultation with national and other state organizations and residents of this state who are stakeholders in all aspects of the health care system that monitor and develop health care quality and safety measures, a proposed standard quality measure set, which, if adopted by the office, would:

(i) Enable health care providers, facilities, medical groups and health care provider groups in this state to report to the office a standard set of information concerning health care quality and safety measures; and

(ii) Include measures concerning health outcomes.

(B) Not later than November 1, 2020, submit the proposed standard quality measure set developed pursuant to subparagraph (A) of this subdivision to the office, and make recommendations to the executive director regarding adoption of such proposed standard quality measure set.

(2) (A) To develop, on an ongoing basis, proposed updates to any standard quality measure set adopted by the office. Such updates may include, but need not be limited to:

(i) Nationally recognized quality measures that are recommended by medical groups and health care provider groups concerning appropriate quality measures for such groups' specialties; and

(ii) Newly developed measures concerning health outcomes, which measures shall meet standards of patient-centeredness and ensure consideration of important differences in preferences and clinical characteristics within patient subpopulations.

(B) The quality council shall provide an opportunity for stakeholder engagement and transparency surrounding any measure development

and research, whether provided by a state agency or third party, relied upon for decision-making that addresses access to health care treatments and services.

(C) Not later than November 1, 2021, and annually thereafter, make recommendations to the executive director regarding adoption of proposed updates to any standard quality measure set adopted by the office.

(3) Advise the office on such other matters that the executive director, in the executive director's discretion, may deem appropriate to assist the office in performing its duties.

Sec. 29. (NEW) (*Effective July 1, 2019*) The office may adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of sections 22 to 28, inclusive, of this act.

Sec. 30. (NEW) (*Effective January 1, 2020, and applicable to sales occurring on or after January 1, 2020*) (a) For the purposes of this section:

(1) "Covered entity" means any individual, partnership, company, firm, public or private corporation, society or association acting as a prescription drug manufacturer, outsourcing facility or wholesaler;

(2) "Opioid drug" has the same meaning as provided in 42 CFR 8.2, as amended from time to time, but does not mean an opioid agonist treatment medication as defined in said section;

(3) "Morphine milligram equivalent" means a unit multiplied by its strength per unit multiplied by the morphine milligram equivalent conversion factor;

(4) "Morphine milligram equivalent conversion factor" means a reference standard for an opioid drug that compares the potency of the opioid drug to morphine, as determined by the federal Centers for Medicare and Medicaid Services;

(5) "Sale" means any transfer of title to an opioid drug for

consideration where actual or constructive possession of the opioid drug is transferred from a covered entity to a purchaser or a purchaser's designee located in this state, but does not mean dispensing an opioid drug to an ultimate consumer pursuant to a prescription or transferring title to an opioid unit from a manufacturer in this state to a purchaser outside this state when such opioid unit will be used or consumed outside this state;

(6) "Strength per unit" means the amount of opioid drug in a unit as measured by concentration, volume, weight or any other metric;

(7) "Unit" means a single finished dosage form of an opioid drug, including, but not limited to, a buccal film, capsule, milligram of topical preparation, milliliter of liquid, pill, suppository, tablet or transdermal patch; and

(8) "Wholesale acquisition cost" means the manufacturer's list price for an opioid drug unit to wholesalers or direct purchasers in the United States, excluding prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.

(b) An excise tax is hereby imposed on the first sale of any opioid drug in this state on or after January 1, 2020, at the following rate:

(1) One-quarter of one cent per morphine milligram equivalent when the wholesale acquisition cost per unit is less than fifty cents; or

(2) One and one-half cents per morphine milligram equivalent when the wholesale acquisition cost per unit is not less than fifty cents.

(c) The excise tax imposed under subsection (b) of this section shall be charged against, and paid by, the covered entity making such first sale, and shall accrue at the time of such first sale. The economic incidence of such tax may be passed to a purchaser. For the purpose of the proper administration of this section and to prevent evasion of

such tax, it shall be presumed that any sale of an opioid drug in this state by a covered entity is the first sale of such opioid drug in this state until the contrary is established, and the burden of proving that any sale is not the first sale in this state shall be upon the covered entity.

(d) Every covered entity liable for the tax imposed under subsection (b) of this section shall file with the Commissioner of Revenue Services a return, on a form prescribed by the commissioner, showing the total morphine milligram equivalent and wholesale acquisition costs of the opioid drugs that are subject to such tax, the amount of tax due thereon, and such further information that the commissioner may require. Such return shall be filed for quarterly periods ending on the last day of March, June, September and December of each year. Each quarterly tax return shall be filed on or before the last day of the month next succeeding the end of each quarterly period and the payment of the taxes due with such return shall be made by the same date. Each covered entity shall file such return electronically with the Department of Revenue Services and make such payment by electronic funds transfer in the manner provided by chapter 228g of the general statutes. If a return is not filed when due, the tax shall be due the day on which the return is required to be filed.

(e) (1) Each covered entity liable for the tax imposed under subsection (b) of this section shall maintain records containing:

(A) The address from which the units are shipped or delivered along with the address to which such units are shipped or delivered; or

(B) The place at which actual physical possession of the units is transferred.

(2) Each covered entity that is required to maintain records pursuant to subdivision (1) of this subsection shall retain such records for a minimum of six years and produce such records to the Commissioner of Revenue Services upon a demand by the commissioner for such

records.

(f) No officer or employee, including, but not limited to, any former officer or former employee, of the state or of any other person who has or had access to a return filed pursuant to subsection (d) of this section or the information contained in such return shall disclose or inspect such return or information except as provided in section 12-15 of the general statutes.

(g) Any tax due and unpaid under this section shall be subject to the penalties and interest established in section 12-547 of the general statutes and the amount of such tax, penalty or interest, due and unpaid, may be collected under the provisions of section 12-35 of the general statutes.

(h) The provisions of sections 12-548, 12-550 to 12-554, inclusive, and 12-555b of the general statutes shall apply to the provisions of this section in the same manner and with the same force and effect as if the language of said sections had been incorporated in full into this section and had expressly referred to the tax imposed under this section, except to the extent that any such provision is inconsistent with a provision of this section.

(i) For the fiscal year ending June 30, 2020, and each fiscal year thereafter, the Comptroller is authorized to record as revenue for each fiscal year the amount of tax imposed under the provisions of this section prior to the end of each fiscal year and which tax is received by the Commissioner of Revenue Services not later than five business days after the last day of July immediately following the end of each fiscal year.

(j) The Commissioner of Revenue Services may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to carry out the provisions of this section.

Sec. 31. (NEW) (*Effective July 1, 2019*) (a) Subject to approval of a waiver described in subsection (f) of this section, for each calendar

month beginning on or after January 1, 2020, each insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity delivering, issuing for delivery, renewing, amending or continuing in this state an individual or group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the general statutes, except for a dental or vision policy or a stop loss policy issued pursuant to section 38a-8b of the general statutes, shall remit to the Insurance Commissioner, on a quarterly basis and in a form and manner prescribed by the commissioner, a surcharge for each policy providing such coverage during such month or any portion of such month. The amount of such surcharge shall be calculated as follows:

(1) If such policy is an individual health insurance policy, ten dollars multiplied by the number of insureds under such policy; or

(2) If such policy is a group health insurance policy, five dollars multiplied by the number of insureds under such policy.

(b) The monthly surcharge imposed under subsection (a) of this section is not premium and shall not be considered premium for any purpose, and no portion of such surcharge shall be refundable or borne by an insured.

(c) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or entity shall remit to the Insurance Commissioner, not later than the thirtieth day of April annually, all monthly surcharges imposed on such company, society, corporation, center or entity under subsection (a) of this section for the calendar year immediately preceding. Each remittance shall include documentation, in a form and manner prescribed by the commissioner, to substantiate the amount of the monthly surcharges being remitted by such company, society, corporation, center or entity.

(d) Not later than the first day of June, annually, the Insurance

Commissioner shall deposit all remittances for the calendar year immediately preceding in the fund established under section 9 of this act.

(e) The surcharge imposed under subsection (a) of this section shall constitute a special purpose assessment for the purposes of section 12-211 of the general statutes.

(f) The surcharge imposed under subsection (a) of this section shall be utilized to establish a reinsurance program for the individual health insurance market, the small employer health insurance market or both such markets, provided the United States Department of the Treasury or the United States Department of Health and Human Services, as applicable, approves an innovation waiver under Section 1332 of the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, for such reinsurance program. Any such reinsurance program shall be administered by the Health Reinsurance Association created under section 38a-556 of the general statutes.

(g) If the surcharge imposed under subsection (a) of this section is determined, upon appeal to and certification by the Insurance Commissioner, to be a retaliatory tax, or if the waiver described in subsection (f) of this section is not approved, such surcharge shall not be imposed.

(h) If any provision of this section is held invalid and inconsistent with other applicable law, such invalidity and inconsistency shall not affect the other provisions of this section.

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

Sec. 32. (NEW) (*Effective July 1, 2019*) For the purposes of this section and sections 33 to 39, inclusive, of this act, unless the context otherwise requires:

(1) "Canadian supplier" means a manufacturer or wholesale drug distributor that is licensed or permitted under applicable Canadian law to manufacture or distribute prescription drugs;

(2) "Drug" means an article that is (A) recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States or official National Formulary, or any supplement thereto, (B) intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in humans, (C) not food and intended to affect the structure or any function of the human body, and (D) not a device and intended for use as a component of any article specified in subparagraphs (A) to (C), inclusive, of this subdivision;

(3) "Drug Quality and Security Act" means the federal Drug Quality and Security Act, 21 USC 351, et seq., as amended from time to time;

(4) "Food, Drug and Cosmetic Act" means the federal Food, Drug and Cosmetic Act, 21 USC 301, et seq., as amended by the Drug Quality and Security Act, as both may be amended from time to time;

(5) "Laboratory" means an environmental laboratory as defined in section 19a-29a of the general statutes and accredited by ISO 17025;

(6) "Laboratory testing" means a quantitative and qualitative analysis of a drug consistent with the official United States Pharmacopoeia;

(7) "Participating Canadian supplier" means a Canadian supplier that is exporting prescription drugs, in the manufacturer's original container, to a participating wholesaler for distribution in this state under the program;

(8) "Participating wholesaler" means a wholesaler that is (A) designated by the Department of Consumer Protection to distribute prescription drugs, in the manufacturer's original container, obtained from a participating Canadian supplier, and (B) participating in the

program;

(9) "Program" means the Canadian prescription drug importation program established by the Commissioner of Consumer Protection, in conjunction with the Commissioner of Public Health, pursuant to section 33 of this act;

(10) "Track-and-trace" means the product tracing process for the components of the pharmaceutical distribution supply chain as described in Title II of the Drug Quality and Security Act; and

(11) "Wholesaler" means a wholesaler, as defined in section 21a-70 of the general statutes, that has received a certificate of registration from the Commissioner of Consumer Protection pursuant to said section.

Sec. 33. (NEW) (*Effective July 1, 2019*) (a) The Commissioner of Consumer Protection, in conjunction with the Commissioner of Public Health, shall establish a program to be known as the "Canadian prescription drug importation program". Under such program, the Commissioner of Consumer Protection and the Commissioner of Public Health shall, notwithstanding any contrary provision of the general statutes, provide for the importation of safe and effective prescription drugs from Canada that have the highest potential for cost savings in this state.

(b) (1) Not later than January 1, 2021, the Commissioner of Consumer Protection shall, after consulting with the Commissioner of Public Health, submit a request to the federal Secretary of Health and Human Services seeking approval for the program under 21 USC 384(*l*), as amended from time to time. Such request shall, at a minimum:

(A) Describe the Commissioner of Consumer Protection's and Commissioner of Public Health's plans for operating the program;

(B) Demonstrate that the prescription drugs that will be imported

and distributed in this state under the program will:

(i) Meet all applicable federal and state standards for safety and effectiveness; and

(ii) Comply with all federal tracing procedures; and

(C) Disclose the costs of implementing the program.

(2) (A) If the federal Secretary of Health and Human Services approves the Commissioner of Consumer Protection's request, the Commissioner of Consumer Protection shall:

(i) Submit to the Commissioner of Public Health a notice disclosing that the federal Secretary of Health and Human Services approved such request;

(ii) Submit to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, general law, human services and public health a notice disclosing that the federal Secretary of Health and Human Services approved such request; and

(iii) Begin operating the program in conjunction with the Commissioner of Public Health not later than one hundred eighty days after the date of such approval.

(B) Except as otherwise provided in sections 32 to 39, inclusive, of this act, the Commissioner of Consumer Protection and the Commissioner of Public Health shall not operate the program unless the federal Secretary of Health and Human Services approves the Commissioner of Consumer Protection's request.

Sec. 34. (NEW) (*Effective July 1, 2019*) Each participating wholesaler may import and distribute a prescription drug in this state from a participating Canadian supplier under the program if:

(1) Such drug meets the United States Food and Drug Administration's standards concerning drug safety, effectiveness,

misbranding and adulteration;

(2) Importing such drug would not violate federal patent laws; and

(3) Such drug is not:

(A) A controlled substance, as defined in 21 USC 802, as amended from time to time;

(B) A biological product, as defined in 42 USC 262, as amended from time to time;

(C) An infused drug;

(D) An intravenously injected drug;

(E) A drug that is inhaled during surgery; or

(F) A drug that is a parenteral drug, the importation of which is determined by the federal Secretary of Health and Human Services to pose a threat to the public health.

Sec. 35. (NEW) (*Effective July 1, 2019*) Participating wholesalers may, subject to the provisions of sections 32 to 39, inclusive, of this act, import and distribute drugs in this state from a participating Canadian supplier under the program to:

(1) A pharmacy or institutional pharmacy, as defined in section 20-571 of the general statutes; and

(2) A laboratory registered with the Department of Public Health under section 19a-29a of the general statutes to perform analytical testing.

Sec. 36. (NEW) (*Effective July 1, 2019*) Each participating Canadian supplier and participating wholesaler shall comply with all applicable track-and-trace requirements, and shall not distribute, dispense or sell outside of this state any prescription drugs that are imported into this state under the program. Each participating wholesaler shall make

available to the Commissioner of Consumer Protection all track-and-trace records not later than forty-eight hours after the Commissioner of Consumer Protection requests such records.

Sec. 37. (NEW) (*Effective July 1, 2019*) (a) The participating wholesaler shall ensure the safety and quality of all drugs that are imported and distributed in this state under the program. The participating wholesaler shall:

(1) For each initial shipment of a drug that is imported into this state by a participating wholesaler, ensure that a laboratory engaged by the participating wholesaler tests a statistically valid sample size for each batch of each drug in such shipment for authenticity and degradation in a manner that is consistent with the Food, Drug and Cosmetic Act;

(2) For each shipment of a drug that is imported into this state by a participating wholesaler and has been sampled and tested pursuant to subdivision (1) of this subsection, ensure that a laboratory engaged by the participating wholesaler tests a statistically valid sample of such shipment for authenticity and degradation in a manner that is consistent with the Food, Drug and Cosmetic Act;

(3) Certify that each drug imported into this state under the program:

(A) Is approved for marketing in the United States and not adulterated or misbranded; and

(B) Meets all of the labeling requirements under 21 USC 352, as amended from time to time;

(4) Maintain laboratory records, including, but not limited to, complete data derived from all tests necessary to ensure that each drug imported into this state under the program is in compliance with the requirements of this section; and

(5) Maintain documentation demonstrating that the testing required by this section was conducted at a laboratory in accordance with the

Food, Drug and Cosmetic Act and all other applicable federal and state laws and regulations concerning laboratory qualifications.

(b) The participating wholesaler shall maintain all information and documentation that is submitted pursuant to this section for a period of not less than three years.

(c) Each participating wholesaler shall maintain all of the following information for each drug that such participating wholesaler imports and distributes in this state under the program, and submit such information to the Commissioner of Consumer Protection upon request by the Commissioner of Consumer Protection:

(1) The name and quantity of the active ingredient of such drug;

(2) A description of the dosage form of such drug;

(3) The date on which such participating wholesaler received such drug;

(4) The quantity of such drug that such participating wholesaler received;

(5) The point of origin and destination of such drug;

(6) The price paid by such participating wholesaler for such drug;

(7) A report for any drug that fails laboratory testing; and

(8) Such additional information and documentation that the Commissioner of Consumer Protection, in consultation with the Commissioner of Public Health, deems necessary to ensure the protection of the public health.

(d) Each participating Canadian supplier shall maintain the following information and documentation and, upon request by the Commissioner of Consumer Protection, submit such information and documentation to the Commissioner of Consumer Protection for each drug that such participating Canadian supplier exports into this state

under the program:

(1) The original source of such drug, including, but not limited to:

(A) The name of the manufacturer of such drug;

(B) The date on which such drug was manufactured; and

(C) The location where such drug was manufactured;

(2) The date on which such drug was shipped;

(3) The quantity of such drug that was shipped;

(4) The quantity of each lot of such drug originally received and the source of such lot;

(5) The lot or control number and the batch number assigned to such drug by the manufacturer; and

(6) Such additional information and documentation that the Commissioner of Consumer Protection, in consultation with the Commissioner of Public Health, deems necessary to ensure the protection of the public health.

Sec. 38. (NEW) (*Effective July 1, 2019*) (a) The Commissioner of Consumer Protection shall issue a written order:

(1) Suspending importation and distribution of a drug under the program if the Commissioner of Consumer Protection discovers that such distribution or importation violates any provision of sections 32 to 39, inclusive, of this act or any other applicable state or federal law or regulation;

(2) Suspending all importation and distribution of drugs by a participating wholesaler under the program if the Commissioner of Consumer Protection discovers that the participating wholesaler has violated any provision of sections 32 to 39, inclusive, of this act or any other applicable state or federal law or regulation;

(3) Suspending all importation and distribution of drugs by a participating Canadian supplier under the program if the Commissioner of Consumer Protection discovers that the participating Canadian supplier has violated any provision of sections 32 to 39, inclusive, of this act or any other applicable state or federal law or regulation; or

(4) Requiring the recall or seizure of any drug that was imported and distributed under the program and has been identified as adulterated, within the meaning of section 21a-105 of the general statutes, or misbranded.

(b) The Commissioner of Consumer Protection shall send a notice to each participating Canadian supplier and participating wholesaler affected by an order issued pursuant to subsection (a) of this section notifying such participating Canadian supplier or participating wholesaler that:

(1) The Commissioner of Consumer Protection has issued such order, and provide the legal and factual basis for such order; and

(2) Such participating Canadian supplier or participating wholesaler may request, in writing, a hearing before the Commissioner of Consumer Protection, provided such request is received by the Commissioner of Consumer Protection not later than thirty days after the date of such notice.

(c) If a hearing is timely requested pursuant to subsection (b) of this section, the Commissioner of Consumer Protection shall, not later than thirty days after the receipt of the request, convene the hearing as a contested case in accordance with the provisions of chapter 54 of the general statutes. Not later than sixty days after the receipt of such request, the Commissioner of Consumer Protection shall issue a final decision vacating, modifying or affirming the Commissioner of Consumer Protection's order. The participating Canadian supplier or participating wholesaler aggrieved by such final decision may appeal such decision in accordance with the provisions of section 4-183 of the

general statutes.

Sec. 39. (NEW) (*Effective July 1, 2019*) The Commissioner of Consumer Protection may, in consultation with the Commissioner of Public Health, adopt regulations in accordance with the provisions of chapter 54 of the general statutes to implement the provisions of sections 32 to 38, inclusive, of this act.

Sec. 40. (NEW) (*Effective July 1, 2019*) Not later than July 1, 2020, and annually thereafter, the executive director of the Office of Health Strategy established under section 19a-754a of the general statutes shall submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, general law, human services and public health. Such report shall describe the operations of the program established pursuant to section 33 of this act during the fiscal year next preceding, and include all information prescribed in regulations adopted pursuant to section 39 of this act.

Sec. 41. Subsection (a) of section 38a-510 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) No insurance company, hospital service corporation, medical service corporation, health care center or other entity delivering, issuing for delivery, renewing, amending or continuing an individual health insurance policy or contract that provides coverage for prescription drugs may:

(1) Require any person covered under such policy or contract to obtain prescription drugs<u>, except for prescription drugs indicated as maintenance drugs in such policy or contract,</u> from a mail order pharmacy as a condition of obtaining benefits for such drugs; or

(2) Require, if such insurance company, hospital service corporation, medical service corporation, health care center or other entity uses step therapy for such drugs, the use of step therapy for (A) any prescribed

drug for longer than sixty days, or (B) a prescribed drug for cancer treatment for an insured who has been diagnosed with stage IV metastatic cancer provided such prescribed drug is in compliance with approved federal Food and Drug Administration indications.

(3) At the expiration of the time period specified in subparagraph (A) of subdivision (2) of this subsection or for a prescribed drug described in subparagraph (B) of subdivision (2) of this subsection, an insured's treating health care provider may deem such step therapy drug regimen clinically ineffective for the insured, at which time the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract. If such provider does not deem such step therapy drug regimen clinically ineffective or has not requested an override pursuant to subdivision (1) of subsection (b) of this section, such drug regimen may be continued. For purposes of this section, "step therapy" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are to be prescribed."

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*	New section
Sec. 7	*July 1, 2019*	38a-1080
Sec. 8	*July 1, 2019*	New section
Sec. 9	*July 1, 2019*	New section
Sec. 10	*July 1, 2019*	New section
Sec. 11	*July 1, 2019*	New section
Sec. 12	*July 1, 2019*	New section
Sec. 13	*January 1, 2022*	12-1

Sec. 14	*January 1, 2022, and applicable to taxable years commencing on or after January 1, 2022*	New section
Sec. 15	*January 1, 2022, and applicable to taxable years commencing on or after January 1, 2022*	New section
Sec. 16	*January 1, 2022, and applicable to taxable years commencing on or after January 1, 2022*	New section
Sec. 17	*January 1, 2022, and applicable to taxable years commencing on or after January 1, 2022*	New section
Sec. 18	*January 1, 2022*	New section
Sec. 19	*January 1, 2022, and applicable to taxable years commencing on or after January 1, 2022*	New section
Sec. 20	*January 1, 2022*	38a-1084
Sec. 21	*July 1, 2019*	19a-754a
Sec. 22	*July 1, 2019*	New section
Sec. 23	*July 1, 2019*	New section
Sec. 24	*July 1, 2019*	New section
Sec. 25	*July 1, 2019*	New section
Sec. 26	*July 1, 2019*	New section
Sec. 27	*July 1, 2019*	New section
Sec. 28	*July 1, 2019*	New section
Sec. 29	*July 1, 2019*	New section
Sec. 30	*January 1, 2020, and applicable to sales occurring on or after January 1, 2020*	New section
Sec. 31	*July 1, 2019*	New section
Sec. 32	*July 1, 2019*	New section
Sec. 33	*July 1, 2019*	New section
Sec. 34	*July 1, 2019*	New section
Sec. 35	*July 1, 2019*	New section
Sec. 36	*July 1, 2019*	New section
Sec. 37	*July 1, 2019*	New section

Sec. 38	*July 1, 2019*	New section
Sec. 39	*July 1, 2019*	New section
Sec. 40	*July 1, 2019*	New section
Sec. 41	*July 1, 2019*	38a-510(a)