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sSB-842
AN ACT CONCERNING HEALTH INSURANCE AND HEALTH CARE IN CONNECTICUT.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 22 $	FY 23 $
Office of the State Comptroller	GF - Cost	At least 600,000	See Below
Office of the State Comptroller	GF - Potential Cost	135,936	135,936
State Comptroller - Fringe Benefits[1]	GF - Potential Cost	55,935	55,935
Connecticut Health Insurance Exchange	CT HIEA - Potential Revenue Gain	Approx 50 million	Approx 50 million
Connecticut Health Insurance Exchange	Other - Potential Cost	Up to 15.3 million	Up to 12.5 million
Connecticut Health Insurance Exchange	CT HIEA - Potential Cost	Approx 50 million	Approx 50 million
Resources of the General Fund	GF - Potential Revenue Gain	None	See Below
Resources of the General Fund	GF - Potential Cost	See Below	See Below
Social Services, Dept.	GF - Cost	36.0 million	61.3 million

Note: GF=General Fund, CT HIEA=Connecticut Health Insurance Exchange Account

Municipal Impact: None

Explanation

The bill makes various changes regarding health insurance, including requiring the Office of the State Comptroller (OSC) to

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 41.3% of payroll in FY 22 and FY 23.

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establish a group health plan for small employers, nonprofits, and multiemployer plans and expanding eligibility for HUSKY A. The bill also requires the Office of Health Strategy (OHS) to develop a plan to lower consumer costs for individual-market health insurance using funds collected from a new fee on health insurers and requires the Connecticut Health Insurance Exchange ("exchange") to implement it.[2] The bill makes various other changes and is anticipated to result in the fiscal impacts described below.

Sections 2 to 3 result in a cost of at least $750,000 in FY 22 to OSC for administrative and personnel costs related to providing health coverage to certain small employers, nonprofits, and multiemployer plans through a fully-insured plan.

There is a cost of at least $600,000 to OSC in FY 22 for consulting services, including actuarial and legal services, to assist with the design and implementation of the plan, evaluate claims experience, and to comply with the Employee Retirement Income Security Act of 1974 (ERISA). Ongoing costs beyond FY 22 will vary depending on the continued need for such services but are anticipated to be less after initial design and implementation. Due to the auditing requirements of the bill, there may be a potential cost to purchase utilization and other health-related data from the plan's carriers.

The requirements of the bill may result in a cost to OSC for two additional benefit officers to support eligible groups who opt for coverage under the new plan. The total annualized salary and fringe benefit costs associated with these two positions is approximately $191,371.

After initial design and implementation, costs related to the administration and support for the new plan may be completely offset by administrative fees when the plan is in place. It is anticipated that any administrative fees charged by carriers will offset the continued

[2] The exchange is a quasi-public agency that funds its operations by charging an assessment on health carriers of 1.65% of premiums in the individual and small group markets. This generated $34.2 million in FY 20.

cost of providing the fully-insured plan.

Some of the bill's requirements are inconsistent with a fully insured model and it is therefore unclear if some of the costs are duplicative or will ultimately be incurred. The bill requires that the Comptroller purchase stop loss insurance, assess a risk fee to participants, and assess administrative fees. These requirements are typically features of a self-insured plan. Under a fully insured model, the administrator of the plan would set and collect premiums, bear the plan's risk, and assess administrative fees to participants.

Sections 5 to 7 require the Comptroller to assess the small employers, nonprofits, and multiemployer plans participating in the Comptroller's group health plan for a share of two existing health insurance industry assessments, the Health and Welfare Fee and the Public Health Fee, to be deposited in the Insurance Fund. This does not result in a fiscal impact to the state. The bill does not change the revenue for the Insurance Fund to be collected from these assessments, which is based on the cost of certain Insurance Fund accounts. The Insurance Fund general assessment, which is also determined based on the cost of certain agencies and accounts, is also unchanged by the bill, to be divided among domestic insurers.

There is no fiscal impact to the Office of the Healthcare Advocate (OHA) to assist enrollees under the Comptroller's new plan like it assists privately insured consumers, as required in **section 8**.

Section 9 results in a potential revenue gain of approximately $50 million in FY 22 and up to approximately $50 million in FY 23 and annually thereafter to the "Connecticut health insurance exchange (CT HIE) account". The CT HIE account is a separate, non-lapsing General Fund account established pursuant to section 13 of the bill. The revenue gain will be realized if the Insurance and Real Estate Committee approves the plan provided by the Office of Health Strategy (OHS) and the exchange, pursuant to section 16. The revenue would be collected as an assessment by the Insurance Department (DOI) on each insurer, health care center and exempt insurer to cover

the plan cost reported by OHS, which cannot exceed $50 million per year. OHS must report that the plan cost is $50 million for 2022. There is no anticipated cost to DOI to carry out the assessment, as it is like others the agency collects from the same entities. In addition to the amount of the assessment, there may be additional minimal revenue deposited in the CT HIE account from fines or penalties assessed by the Insurance Commissioner associated with collecting the new assessment. There is also potential revenue to the CT HIE account from the coverage fee to be assessed by the Comptroller pursuant to section 3, depending on plan enrollment.[3]

Sections 10, 11 and 16 result in potential costs for the exchange from the exchange's own resources and the CT HIE account (state costs), dependent on the plan developed by OHS being approved. If the plan is approved, the exchange would incur costs, presumably from its own resources, of (1) at least $100,000 in FY 22 for an actuarial report to support the state's application for a Section 1332 State Innovation Waiver[4] and (2) up to $14.4 million in FY 22 and up to $12.5 million annually thereafter to establish the subsidiary exchange and operate it.[5]

Using funds in the CT HIE account, the exchange would incur the following state costs:

(1) up to $25 million annually for subsidies for people ineligible to buy qualified health plans (QHP) on the exchange,

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[3] The amount would equal the amount of the Insurance Fund fee a domestic insurance company would pay for providing the same amount of fully-insured coverage as the Comptroller under the new plan. The Insurance Fund fee is set to the amount required to fund certain appropriations less the fund balance and was $33.2 million for FY 21. It applies to all types of admitted domestic insurers (including life, property and casualty, etc.).

[4] $100,000 reflects the cost of a report to support a waiver for a reinsurance program; there may be additional consulting services costs to demonstrate that other proposed program aspects meet the federal requirements for state innovation waiver approval.

[5] Most anticipated costs are for technology and vendor contracts for operations. The ability for the exchange to leverage existing functionality is anticipated to be limited by rules in the federal Affordable Care Act (ACA).

(2) up to $20 million annually to fund a reinsurance program,[6]

(3) $1.7 to $3.5 million in FY 22 and $5.3 to $7.5 million in FY 23 to eliminate premium costs for exchange enrollees with household incomes up to 200% of the federal poverty level (FPL).[7]

(4) significant costs, the amount of which is dependent on the design of the program, to reduce the cost of premiums and cost-sharing for exchange enrollees with household incomes greater than 200% FPL and any other actions necessary to implement the Section 1332 waiver program if federal approval for it is granted. As an example, the cost for an average subsidy of $1,000 for the approximately 75,000 exchange enrollees with household incomes above 200% of FPL would be $75 million, excluding administration.

As the state costs could easily exceed the moneys available in the CT HIE account designated by the bill to pay for these requirements (approximately $50 million), it is unclear what aspects of the plan would be funded and at what level.

These sections may also result in a revenue gain to the General Fund beginning as early as FY 23. Generally, Section 1332 waiver programs generate new state revenue from the federal government (known as "pass-through" funding) which can partially fund the program. The amount is based on how much the program reduces federal premium tax credits for Connecticut exchange enrollees. Previous research has estimated that a reinsurance program with a state investment of $19.5 million could generate $23 million or more in federal pass-through

[6] The cost of a reinsurance program is primarily for reinsurance payments but would also include $150,000 to $500,000 in annual expenses for administration, depending on program complexity and assuming the Health Reinsurance Association would operate the program through a third-party administrator.

[7] These estimates include the impact of temporarily increased federal subsidies for exchange enrollees in 2021 and 2022 and reflect the assumption that exchange enrollees likely to be eligible for HUSKY A under the bill will switch to that coverage. Premium inflation of 2% and 5% over 2021 rates is assumed for FY 22, and FY 23 costs, respectively. Future year costs would be higher unless the increased federal subsidies are extended.

funding.[8] Any such revenue would be received annually while the waiver was in effect, after the waiver was applied for and approved.

Section 14 may result in a cost to the state going forward pursuant to the federal Affordable Care Act (ACA) for costs related to the coverage of blood pressure monitors and peak flow meters under QHP sold on the exchange.[9] While most of the mandated benefits in Section 14 are understood to be included in the benchmark plan, and therefore not anticipated to trigger any ACA-required defrayment of the premium cost for exchange enrollees, coverage under the benchmark plan for blood pressure monitors and peak flow meters is understood to be restricted to enrollees participating in certain carrier programs. To the extent that expanding coverage of those devices to all those specified in the bill results in higher premium costs, the state will be responsible for the corresponding premium increases in exchange plans, which are not expected to be significant.

Section 16, which also requires that OHS submit a report, made in consultation with the Department of Social Services (DSS) and the exchange, on whether or not the state should seek a Section 1115 waiver, is not anticipated to result in a fiscal impact to OHS, nor are other provisions of the bill.

Section 17 results in a cost to DSS of approximately $36 million in FY 22 and $61.3 million in FY 23 associated with increasing income eligibility under HUSKY A to 206% of the federal poverty level (FPL) from 160% FPL, inclusive of the income disregard.[10]

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[8] Research by Wakely Consulting Group, LLC. commissioned by the exchange and reported in February 2020. Note that such estimates may no longer be accurate due to significant shifts in the individual insurance market from the COVID-19 pandemic and changes to federal subsidies under the American Rescue Plan.

[9] The ACA requires that QHP offered on the exchange include the federally-defined essential health benefits package (EHB). States can mandate benefits in excess of the EHB, however if the benefits are not already covered under the state's benchmark plan, federal law requires the state to defray the cost of any such additional mandated benefits for all plans sold in the exchange, by reimbursing the carrier or the insured for the excess coverage.

[10] The 5% income disregard under modified adjusted gross income (MAGI) standards effectively makes 201% equal 206% FPL.

Section 18 results in a cost to the exchange, from its own resources, of up to $750,000 for technology upgrades to its system necessary for receiving referrals from the Labor Department and determining eligibility for coverage or assistance of those applying for unemployment compensation benefits.

The Out Years

The fiscal impacts identified above will continue subject to approval of the OHS plan, enrollment in the Comptroller's group health plan, enrollment and premiums in the individual health insurance market on the exchange and its subsidiary exchange, federal approval of a Section 1332 waiver, actual savings to the federal government under an approved Section 1332 waiver, federal action on health insurance subsidies, and the number of newly eligible individuals and associated costs under HUSKY A.

Sources: *ConnectiCare benchmark plan and formulary documents*
Connecticut Health Insurance Exchange
Department of Social Services
Office of the State Comptroller