OFFICE OF FISCAL ANALYSIS

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SB-1004
AN ACT CONCERNING DENTAL AND VISION INSURANCE COVERAGE FOR CHILDREN, STEPCHILDREN AND OTHER DEPENDENT CHILDREN.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 22 $	FY 23 $
State Comptroller - Fringe Benefits	GF - Cost	None	See Below
ACA – State Mandate	GF - Cost	See Below	See Below

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 22 $	FY 23 $
Various Municipalities	STATE MANDATE[1] - Cost	See Below	See Below

Explanation

The bill will result in a cost starting in FY 23 from requiring both the state employee and retiree dental and health plans to maintain dental and vision coverage for dependents until the earlier of a dependent gaining coverage through their own employment or the age of 26; coverage is currently until age 19. The state dental plan is fully insured with new rates effective each July 1st. Therefore there is no impact to the state plan in FY 22. The bill will increase dental premiums for fully

[1] State mandate is defined in Sec. 2-32b(2) of the Connecticut General Statutes, "state mandate" means any state initiated constitutional, statutory or executive action that requires a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.

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insured municipalities and will be realized in premiums when they enter into a new policy after January 1, 2022.

In addition, many municipal health plans are recognized as "grandfathered" health plans under the Affordable Care Act (ACA).[2] It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA. Pursuant to federal law, municipalities with self-insured plans are exempt from state insurance mandates.

Lastly, the bill may result in a cost to the state pursuant to the ACA, to the extent the provisions of the bill are interpreted to require the expansion of the pediatric dental and vision benefits provided to comply with the essential health benefit (EHB) requirement.[3] While states are allowed to mandate benefits in excess of the EHB, 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. Absent further federal guidance, state mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB unless they are already part of the benchmark plan.[4]

The Out Years

The fiscal impact described above will continue into the future and be reflected in future dental premiums. In addition, the potential cost to the state pursuant to the ACA will depend on the cost to provide the benefit to Exchange plan members, as reflected in premiums.

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[2] Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010.

[3] There are approximately 9,000 Exchange plan members between the ages of 19-26. (*Source: Access Health CT*)

[4] The ACA provision does not apply to stand alone dental polices or those policies provided as a rider to the health policy.