AN ACT CONCERNING HEALTH INSURANCE AND HEALTH CARE IN CONNECTICUT.

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

Section 1. Section 3-123rrr of the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2021):

As used in this section, [and] sections 3-123sss to 3-123vvv, inclusive, [and] as amended by this act, section 3-123xxx and section 2 of this act:

(1) "Health Care Cost Containment Committee" means the committee established in accordance with the ratified agreement between the state and the State Employees Bargaining Agent Coalition pursuant to subsection (f) of section 5-278.

(2) "Health enhancement program" means the program established in accordance with the provisions of the Revised State Employees Bargaining Agent Coalition agreement, approved by the General Assembly on August 22, 2011, for state employees, as amended by stipulated agreements.
"Multiemployer plan" has the same meaning as provided in Section 3 of the Employee Retirement Income Security Act of 1974, as amended from time to time.

"Nonstate public employee" means any employee or elected officer of a nonstate public employer.

"Nonstate public employer" means a municipality or other political subdivision of the state, including a board of education, quasi-public agency or public library. A municipality and a board of education may be considered separate employers.

"Nonprofit employer" means a nonprofit, nonstock corporation, other than a nonstate public employer, that employs at least one employee on the first day that such employer receives coverage under a group hospitalization, medical, pharmacy and surgical insurance plan offered by the Comptroller pursuant to this part.

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

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

"Health enhancement program" means the program established in accordance with the provisions of the Revised State Employees Bargaining Agent Coalition agreement, approved by the General Assembly on August 22, 2011, for state employees, as may be amended by stipulated agreements.

"Value-based insurance design" means health benefit designs
that lower or remove financial barriers to essential, high-value clinical services.

[(7) "Health care coverage type" means the type of health care coverage offered by nonstate public employers, including, but not limited to, coverage for a nonstate public employee, nonstate public employee plus spouse and nonstate public employee plus family.]

Sec. 2. (NEW) (Effective July 1, 2021) (a) (1) Notwithstanding any provision of title 38a of the general statutes, the Comptroller shall offer to plan participants and beneficiaries in this state under a multiemployer plan, nonprofit employers and their employees and small employers and their employees coverage under the state employee plan or another group hospitalization, medical, pharmacy and surgical insurance plan developed by the Comptroller to provide coverage for plan participants and beneficiaries in this state under a multiemployer plan, nonprofit employers and their employees and small employers and their employees. Plan participants and beneficiaries in this state under a multiemployer plan, nonprofit employers and their employees and small employers and their employees receiving coverage provided pursuant to this section shall be pooled with state employees and retirees under the state employee plan, provided the administrator of the multiemployer plan, the nonprofit employer or the small employer files an application with the Comptroller for coverage pursuant to this section and the Comptroller approves such application. The administrators of multiemployer plans, nonprofit employers or small employers shall remit to the Comptroller payments for coverage provided pursuant to this section. Such payments shall be equal to the payments paid by the state for state employees covered under the state employee plan, inclusive of any premiums paid by state employees pursuant to the state employee plan, except premium payments may be adjusted to reflect:

(A) Age, in accordance with a uniform age rating curve that satisfies the requirements established under the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and
regulations adopted thereunder;

(B) Geographic area;

(C) Family size, provided premium payments for family coverage shall not exceed the lesser of:

(i) The sum of the premium payments for all covered family members; or

(ii) The sum of the premium payments for:

(I) All covered family members who are twenty-one years of age or older; and

(II) The eldest three covered children who are younger than twenty-one years of age;

(D) Actuarially justified differences in:

(i) Plan design;

(ii) A plan's health care provider network; or

(iii) Administrative costs that can be reasonably attributed to a plan; and

(E) The actual performance of a multiemployer plan, nonprofit employer or small employer receiving coverage provided pursuant to this section, provided such adjustment shall not cause the premiums charged for such multiemployer plan, nonprofit employer or small employer to increase or decrease by an amount that is greater than three per cent of the premiums that would otherwise be charged for such multiemployer plan, nonprofit employer or small employer under this subdivision.

(2) Coverage provided pursuant to this section shall:

(A) Include the health enhancement program;
(B) Be consistent with value-based insurance design principles;

(C) Be approved by the Health Care Cost Containment Committee during a public meeting; and

(D) Include coverage for:

(i) All health care services and benefits that each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state is required to cover under chapter 700c of the general statutes; and

(ii) All health care services and benefits that are essential health benefits, as defined in the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and regulations adopted thereunder.

(3) The Comptroller may charge each multiemployer plan, nonprofit employer and small employer receiving coverage provided pursuant to this section an administrative fee calculated on a per member, per month basis. Such administrative fee may include brokers' fees.

(b) (1) The Comptroller shall offer coverage under this section for intervals lasting not less than:

(A) Three years for:

(i) Multiemployer plans; and

(ii) Nonprofit employers that are not small employers; or

(B) One year for small employers.

(2) The administrator of each multiemployer plan, nonprofit employer or small employer receiving coverage pursuant to this section may apply to renew such coverage before the interval applicable to such multiemployer plan, nonprofit employer or small employer under
subdivision (1) of this subsection expires.

(c) The Comptroller shall require each administrator of a multiemployer plan, nonprofit employer and small employer receiving coverage under this section to offer coverage under this section to all of such multiemployer plan's participants and beneficiaries in this state, nonprofit employer's employees in this state and small employer's employees in this state who are eligible for health coverage. The administrator of such multiemployer plan, nonprofit employer or small employer shall not offer coverage under this section in addition to, or in conjunction with, any other health coverage option, except an employer's active employees and retirees may be treated as independent groups for the purposes of this subsection.

(d) (1) The Comptroller shall develop and establish:

(A) Procedures by which the administrator of a multiemployer plan, nonprofit employer or small employer may initially apply for, renew and withdraw from coverage provided pursuant to this section;

(B) Rules of participation that the Comptroller, in the Comptroller's discretion, deems necessary; and

(C) Accounting procedures to track claims and premium payments paid by multiemployer plans, nonprofit employers and small employers receiving coverage provided pursuant to this section.

(2) The Comptroller shall procure such services, including, but not limited to, services necessary to ensure compliance with the Employee Retirement Income Security Act of 1974, as amended from time to time, and regulations adopted thereunder, that the Comptroller deems necessary to administer coverage provided pursuant to this section. The Comptroller shall make an assessment against the multiemployer plans, nonprofit employers and small employers receiving coverage provided pursuant to this section to recover the cost of such services. Such assessment shall be made on a per employee, per month basis and shall be considered an administrative fee.
(e) The Comptroller shall make reasonable efforts to minimize the risk that coverage provided pursuant to this section poses to the state's finances. In making such reasonable efforts, the Comptroller may, among other things:

(1) Purchase an aggregate stop-loss insurance policy on behalf of all multiemployer plans, nonprofit employers and small employers receiving coverage provided pursuant to this section;

(2) Purchase a stop-loss insurance policy on behalf of an individual multiemployer plan, nonprofit employer or small employer receiving coverage provided pursuant to this section; and

(3) Establish a risk fund to pay claims that exceed the premiums collected for a multiemployer plan, nonprofit employer or small employer receiving coverage provided pursuant to this section, fund such risk fund through a charge levied on such multiemployer plans, nonprofit employers and small employers and establish operating procedures for use of such fund.

(f) (1) Nothing in this section shall be construed to:

(A) Require the Comptroller to offer coverage under the state employee plan to every multiemployer plan, nonprofit employer and small employer seeking coverage under the state employee plan pursuant to this section; or

(B) Prevent the Comptroller from:

(i) Procuring coverage for nonstate public employees from vendors other than the vendors providing coverage to state employees; or

(ii) Offering plan designs or benefit coverage levels pursuant to this section that differ from the plan designs and benefit coverage levels offered to state employees, provided the Comptroller shall not offer any coverage pursuant to this section that imposes a deductible that is greater than the minimum deductible required by the Internal Revenue Service for such coverage to qualify as a high deductible health plan, as
defined in Section 220(c)(2) or Section 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time.

(2) No coverage offered by the Comptroller pursuant to this section shall be deemed to constitute a multiple employer welfare arrangement, as defined in Section 3 of the Employee Retirement Income Security Act of 1974, as amended from time to time.

Sec. 3. Section 3-123vvv of the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2021):

The Comptroller shall not offer coverage under the state employee plan pursuant to sections 3-123rrr to 3-123uuu, inclusive, as amended by this act, or section 2 of this act until the State Employees' Bargaining Agent Coalition has provided its consent to the clerks of both houses of the General Assembly to incorporate the terms of sections 3-123rrr to 3-123uuu, inclusive, as amended by this act, and section 2 of this act into its collective bargaining agreement.

Sec. 4. (NEW) (Effective July 1, 2021) (a) For the purposes of this section:

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

(2) "Exempt insurer" means an insurer that administers self-insured health benefit plans and is exempt from third-party administrator licensure under subparagraph (C) of subdivision (11) of section 38a-720 of the general statutes and section 38a-720a of the general statutes; and

(3) "Office of Health Strategy" means the Office of Health Strategy established under section 19a-754a of the general statutes.

(b) (1) Subject to the approval required under subsection (d) of section 10 of this act and, with respect to the matters for which the exchange seeks a state innovation waiver pursuant to subparagraph (B) of subdivision (28) of section 38a-1084 of the general statutes, issuance of
such state innovation waiver, the Office of Health Strategy, not later than September 1, 2021, for plan year 2022 and annually thereafter for the succeeding plan year, shall:

(A) Determine the amount, not to exceed fifty million dollars, that the exchange requires to perform its duties under subparagraph (C) of subdivision (28) of section 38a-1084 of the general statutes, as amended by this act; and

(B) Inform the Office of Policy and Management of the amount determined pursuant to subparagraph (A) of this subdivision.

(2) The Office of Policy and Management shall disclose the amount determined pursuant to subparagraph (A) of subdivision (1) of this subsection to the Insurance Commissioner and the exchange.

(c) (1) Each insurer and health care center doing health insurance business in this state, and each exempt insurer, shall annually pay to the Insurance Commissioner, for deposit in the Connecticut Health Insurance Exchange account established under section 7 of this act, a fee assessed by the commissioner pursuant to this section.

(2) Not later than September 1, 2021, and annually thereafter, each insurer, health care center and exempt insurer described in subdivision (1) of this subsection shall report to the commissioner, on a form designated by said commissioner, the number of insured or enrolled lives in this state as of the May first immediately preceding for which such insurer, health care center or exempt insurer was providing health insurance coverage, or administering a self-insured health benefit plan providing coverage, of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes. Such number shall not include lives enrolled in Medicare, any medical assistance program administered by the Department of Social Services, workers' compensation insurance or Medicare Part C plans.

(3) Not later than November 1, 2021, and annually thereafter, the commissioner shall determine the fee to be assessed for the succeeding
plan year against each insurer, health care center and exempt insurer described in subdivision (1) of this subsection. Such fee shall be calculated by multiplying the number of insured or enrolled lives reported to the commissioner pursuant to subdivision (2) of this subsection by a factor, determined annually by the commissioner, to fully fund the amount determined by the Office of Health Strategy under subparagraph (A) of subdivision (1) of subsection (b) of this section, adjusted by subtracting, if the amount appropriated was more than the amount expended, or by adding, if the amount expended was more than the amount appropriated, the amount determined by the Office of Health Strategy under subparagraph (A) of subdivision (1) of subsection (b) of this section, less the amount of any federal pass-through savings available pursuant to the waiver described in subdivision (1) of subsection (b) of this section. The commissioner shall determine the factor by dividing the adjusted amount by the total number of insured or enrolled lives reported to the commissioner pursuant to subdivision (2) of this subsection.

(4) (A) Not later than December 1, 2021, and annually thereafter, the commissioner shall submit a statement to each insurer, health care center and exempt insurer described in subdivision (1) of this subsection that includes the proposed fee imposed under this section for such insurer, health care center or exempt insurer calculated in accordance with this subsection. Each such insurer, health care center and exempt insurer shall pay such fee to the commissioner not later than February first of the succeeding calendar year.

(B) Any insurer, health care center or exempt insurer described in subdivision (1) of this subsection that is aggrieved by an assessment levied under this subsection may appeal therefrom in the same manner as provided for appeals under section 38a-52 of the general statutes.

(5) Any insurer, health care center or exempt insurer that fails to file the report required under subdivision (2) of this subsection shall pay a late filing fee of one hundred dollars per day for each day from the date such report was due. The commissioner may require an insurer, health
care center or exempt insurer subject to this subsection to produce any
records in its possession, and may require any other person to produce
any records in such other person's possession, that were used to prepare
such report for examination by the commissioner or the commissioner's
designee. If the commissioner determines there exists anything other
than a good faith discrepancy between the actual number of insured or
enrolled lives that should have been reported pursuant to subdivision
(2) of this subsection and the number actually reported, such insurer,
health care center or exempt insurer shall pay a civil penalty of not more
than fifteen thousand dollars for each report filed for which the
commissioner determines there is such a discrepancy.

(6) (A) The commissioner shall apply an overpayment of the fee
imposed under this section by an insurer, health care center or exempt
insurer for any plan year as a credit against the fee due from such
insurer, health care center or exempt insurer under this section for the
succeeding plan year, subject to an adjustment under subdivision (3) of
this subsection, if:

(i) The amount of the overpayment exceeds five thousand dollars;
and

(ii) On or before June first of the calendar year of the overpayment,
the insurer, health care center, or exempt insurer:

(I) Notifies the commissioner of the amount of the overpayment; and

(II) Provides the commissioner with evidence sufficient to prove the
amount of the overpayment.

(B) Not later than ninety days following receipt of notice and
supporting evidence under subparagraph (A) of this subdivision, the
commissioner shall:

(i) Determine whether the insurer, health care center or exempt
insurer made an overpayment; and

(ii) Notify the insurer, health care center or exempt insurer of the
commissioner's determination under subparagraph (B)(i) of this subdivision.

(C) Failure of an insurer, health care center or exempt insurer to notify the commissioner of the amount of an overpayment within the time prescribed in subparagraph (A)(ii) of this subdivision constitutes a waiver of any demand of the insurer, health care center or exempt insurer against this state on account of such overpayment.

(D) Nothing in this subdivision shall be construed to prohibit or limit the right of an insurer, health care center or exempt insurer to appeal pursuant to subparagraph (B) of subdivision (4) of this subsection.

(d) The exchange shall use the assessment imposed under this section to perform the exchange's duties under subparagraph (C) of subdivision (28) of section 38a-1084 of the general statutes, as amended by this act.

(e) If another state, territory or district of the United States, or a foreign country, imposes on a Connecticut domiciled insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other domestic entity a retaliatory charge for the fee imposed under this section, such domestic entity may, not later than sixty days after receipt of notice of the imposition of the retaliatory charge for such fee, appeal to the Insurance Commissioner for a verification that the fee imposed under this section is subject to retaliation by another state, territory or district of the United States, or a foreign country. If the commissioner verifies, upon appeal to and certification by the commissioner, that the fee imposed under this section is the subject of a retaliatory tax, fee, assessment or other obligation by another state, territory or district of the United States, or a foreign country, such fee shall not be assessed against nondomestic insurers and nondomestic exempt insurers pursuant to this section. Any such domestic insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity aggrieved by the commissioner's decision issued under this subsection may appeal therefrom in the same manner as provided
under section 38a-52 of the general statutes.

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

Sec. 5. Section 38a-1080 of the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2021):

For purposes of sections 38a-1080 to 38a-1093, inclusive, as amended by this act, and sections 7 and 8 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. 6. Section 38a-1084 of the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2021):

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, an individual is exempt from the individual responsibility requirement or from the penalty imposed by said Section 5000A 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 penalty;

(16) Provide to the Secretary of the Treasury of the United States the following:

(A) 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) 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) The employer did not provide minimum essential health benefits coverage; or
(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) The name and taxpayer identification number of:
(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) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

(17) Provide to each employer the name of each employee, as described in subparagraph (B) 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 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
Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange;

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;

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;

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;

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; [.]

(26) Administer the Connecticut Health Insurance Exchange account established under section 7 of this act;

(27) Consult with the Office of Health Strategy established under section 19a-754a, as amended by this act, for the purposes set forth in subsection (b) of section 10 of this act;

(28) Subject to the approval required under subsection (d) of section 10 of this act:

(A) Establish the subsidiary described in subdivision (1) of subsection (b) of section 10 of this act not later than November 1, 2021;

(B) Seek the state innovation waiver described in subdivision (2) of subsection (b) of section 10 of this act not later than November 1, 2021; and

(C) Use the moneys deposited in the Connecticut Health Insurance Exchange account established under section 7 of this act for the purposes set forth in subdivision (3) of subsection (b) of section 10 of this act;

(29) Consult with the Commissioner of Social Services for the purposes set forth in subsection (b) of section 17b-597, as amended by this act;

(30) Implement, with assistance from the Commissioner of Social Services, the policies and procedures necessary to carry out the provisions of section 17b-597, as amended by this act; and

(31) Determine whether individuals referred to the exchange by the Labor Commissioner pursuant to section 14 of this act are eligible for free or subsidized health coverage or other assistance or benefits,
including, but not limited to, assistance under the supplemental nutrition assistance program, and, if such individuals are eligible for such coverage, assistance or benefits, enroll such individuals in such coverage, assistance or benefits.

Sec. 7. (NEW) (Effective July 1, 2021) There is established an account to be known as the "Connecticut Health Insurance Exchange account" which shall be a separate, nonlapsing account within the General Fund. The account shall contain any moneys required by law to be deposited in the account. Moneys in the account shall be expended by the exchange for the purposes set forth in subparagraph (C) of subdivision (28) of section 38a-1084 of the general statutes, as amended by this act.

Sec. 8. (NEW) (Effective July 1, 2021) (a) Notwithstanding any provision of the general statutes and to the extent permitted by federal law, each qualified health plan that is offered through the exchange at a silver level of coverage for a plan year beginning on or after January 1, 2022, shall provide coverage for the following benefits:

1. Angiotensin converting enzyme inhibitors for an enrollee who is diagnosed with congestive heart failure, diabetes or coronary artery disease by a licensed health care provider who is acting within such health care provider's scope of practice;

2. Anti-resorptive therapy for an enrollee who is diagnosed with osteoporosis or osteopenia by a licensed health care provider who is acting within such health care provider's scope of practice;

3. Beta-adrenergic blocking agents for an enrollee who is diagnosed with congestive heart failure or coronary artery disease by a licensed health care provider who is acting within such health care provider's scope of practice;

4. Blood pressure monitors for an enrollee who is diagnosed with hypertension by a licensed health care provider who is acting within such health care provider's scope of practice;
(5) Inhaled corticosteroids and peak flow meters for an enrollee who is diagnosed with asthma by a licensed health care provider who is acting within such health care provider's scope of practice;

(6) Insulin and other glucose lowering agents, retinopathy screening, glucometers and hemoglobin A1C testing for an enrollee who is diagnosed with diabetes by a licensed health care provider who is acting within such health care provider's scope of practice;

(7) International normalized ratio testing for an enrollee who is diagnosed with liver disease or a bleeding disorder by a licensed health care provider who is acting within such health care provider's scope of practice;

(8) Low density lipoprotein testing for an enrollee who is diagnosed with heart disease by a licensed health care provider who is acting within such health care provider's scope of practice;

(9) Selective serotonin reuptake inhibitors for an enrollee who is diagnosed with depression by a licensed health care provider who is acting within such health care provider's scope of practice; and

(10) Statins for an enrollee who is diagnosed with heart disease or diabetes by a licensed health care provider who is acting within such health care provider's scope of practice.

(b) Notwithstanding any provision of the general statutes and to the extent permitted by federal law, each qualified health plan described in subsection (a) of this section shall:

(1) Have a minimum actuarial value of at least seventy per cent; and

(2) Provide enrollees with access to the broadest provider network available under the qualified health plans offered by the health carrier through the exchange.

Sec. 9. Subsections (a) and (b) of section 19a-754a of the general statutes are repealed and the following is substituted in lieu thereof
(Effective July 1, 2021):

(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. Directing and overseeing the State Innovation Model Initiative
and related successor initiatives;

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 section 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; []

(7) Annually (A) determining the amount described in subparagraph (A) of subdivision (1) of subsection (b) of section 4 of this act, and (B) informing the Office of Policy and Management of such amount pursuant to subparagraph (B) of subdivision (1) of subsection (b) of section 4 of this act; and

(8) Developing a plan pursuant to subsection (b) of section 10 of this act and submitting a report containing such plan pursuant to subsection (c) of section 10 of this act.

Sec. 10. (Effective July 1, 2021) (a) For the purposes of this section:

(1) "Account" means the Connecticut Health Insurance Exchange account established under section 7 of this act;

(2) "Affordable Care Act" has the same meaning as provided in section 38a-1080 of the general statutes, as amended by this act;

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

(4) "Office of Health Strategy" means the Office of Health Strategy established under section 19a-754a 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 Office of Health Strategy shall, in consultation with the exchange, develop a plan for the exchange to:

(1) Establish a subsidiary, in the manner set forth in section 38a-1093
of the general statutes, to create a marketplace for health carriers to offer
affordable health insurance coverage to persons who are ineligible for
coverage under the qualified health plans offered through the exchange;

(2) Seek a state innovation waiver pursuant to Section 1332 of the
Affordable Care Act for the purpose of:

(A) Reducing the cost of health insurance coverage in this state,
including, but not limited to, premiums and cost-sharing for such
coverage;

(B) Making health insurance coverage available to persons in this
state who are ineligible for coverage under a qualified health plan
offered through the exchange; and

(C) Allowing persons specified in subsection (a) of section 17b-597 of
the general statutes, as amended by this act, to receive coverage for
medical assistance under section 17b-597 of the general statutes, as
amended by this act, through the exchange; and

(3) For plan year 2022 and subsequent plan years, use the moneys
deposited in the account to:

(A) Reduce the cost of qualified health plans offered through the
exchange by, among other things, eliminating premiums for such
qualified health plans for persons with a household income not
exceeding two hundred one per cent of the federal poverty level;

(B) Make coverage affordable for persons who are ineligible for
coverage under a qualified health plan offered through the exchange by,
among other things, providing premium and cost-sharing subsidies to
such persons which, in the aggregate for all such persons, shall not
exceed twenty-five million dollars per year; and

(C) Implement the provisions of the state innovation waiver
described in subdivision (2) of this subsection if the federal government
issues such waiver for this state.
(c) Not later than August 1, 2021, the Office of Health Strategy shall submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance. Such report shall contain the plan developed pursuant to subsection (b) of this section.

(d) Not later than October 1, 2021, the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall advise the Office of Health Strategy and the exchange of its approval or rejection of the plan contained in the report submitted by the Office of Health Strategy pursuant to subsection (c) of this section. If the committee does not act on or before said date, said plan shall be deemed rejected.

Sec. 11. Section 17b-597 of the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2021):

(a) The Department of Social Services shall establish and implement a working persons with disabilities program to provide medical assistance as authorized under 42 USC 1396a(a)(10)(A)(ii), as amended from time to time, to persons who are disabled and regularly employed.

(b) The Commissioner of Social Services shall amend the Medicaid state plan to develop, in consultation with the Connecticut Health Insurance Exchange established pursuant to section 38a-1081, a methodology to determine eligibility for the program established and implemented by the commissioner pursuant to subsection (a) of this section and allow persons specified in said subsection [(a) of this section] to qualify for medical assistance regardless of assets. The amendment shall include the following requirements: (1) That the person be engaged in a substantial and reasonable work effort as determined by the commissioner, or, if the amendment is approved, the exchange, and as permitted by federal law; and [have an annual adjusted gross income, as defined in Section 62 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, of no more than]
seventy-five thousand dollars per year; (2) a disregard of all countable income up to two hundred per cent of the federal poverty level; (3) for an unmarried person, an asset limit of ten thousand dollars, and for a married couple, an asset limit of fifteen thousand dollars; (4) a disregard of any retirement and medical savings accounts established pursuant to 26 USC 220 and held by either the person or the person's spouse; (5) a disregard of any moneys in accounts designated by the person or the person's spouse for the purpose of purchasing goods or services that will increase the employability of such person, subject to approval by the commissioner; (6) a disregard of spousal income solely for purposes of determination of eligibility; and (7) a contribution of any countable income of the person or the person's spouse which exceeds two hundred per cent of the federal poverty level, as adjusted for the appropriate family size, equal to ten per cent of the excess minus any premiums paid from income for health insurance by any family member, but which does not exceed the maximum contribution allowable under Section 201(a)(3) of Public Law 106-170, as amended from time to time.

(c) The Commissioner of Social Services shall (1) not later than August 1, 2021, seek federal approval for a Medicaid state plan amendment to implement the provisions of subsection (b) of this section; and (2) assist the Connecticut Health Insurance Exchange, established pursuant to section 38a-1081, to implement the policies and procedures necessary to carry out the provisions of this section while the commissioner is in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt the regulations is published [in the Connecticut Law Journal within] on the Internet web site of the Department of Social Services and the eRegulations System not later than twenty days after implementation. The commissioner and the exchange shall define "countable income" for purposes of subsection (b) of this section which shall take into account impairment-related work expenses as defined in the Social Security Act. Such policies and procedures shall be valid until the time final regulations are effective.
Sec. 12. Section 17b-598 of the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2021):

The Commissioner of Social Services shall seek a waiver from federal law to permit a person participating in the program established under section 17b-597, as amended by this act, to remain eligible for medical assistance under the Medicaid program in the event such person is unable to maintain a work effort for involuntary reasons. No such person shall be required to make another application to determine continued eligibility for medical assistance under the Medicaid program. In order to remain eligible for such medical assistance, such person shall (1) request that such assistance be continued for a period not to exceed twelve months from the date of the involuntary loss of employment, and (2) maintain a connection to the workforce as determined by the commissioner during such period. At the end of the twelve-month period, such person shall meet the eligibility criteria for the Medicaid program,[,] except that the commissioner shall disregard any assets specified in subdivisions (4) and (5) of subsection (b) of section 17b-597.]

Sec. 13. Subsection (a) of section 17b-261 of the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2021):

(a) Medical assistance shall be provided for any otherwise eligible person whose income, including any available support from legally liable relatives and the income of the person's spouse or dependent child, is not more than one hundred forty-three per cent, pending approval of a federal waiver applied for pursuant to subsection (e) of this section, of the benefit amount paid to a person with no income under the temporary family assistance program in the appropriate region of residence and if such person is an institutionalized individual as defined in Section 1917 of the Social Security Act, 42 USC 1396p(h)(3), and has not made an assignment or transfer or other disposition of property for less than fair market value for the purpose of establishing eligibility for benefits or assistance under this section. Any such
disposition shall be treated in accordance with Section 1917(c) of the
Social Security Act, 42 USC 1396p(c). Any disposition of property made
on behalf of an applicant or recipient or the spouse of an applicant or
recipient by a guardian, conservator, person authorized to make such
disposition pursuant to a power of attorney or other person so
authorized by law shall be attributed to such applicant, recipient or
spouse. A disposition of property ordered by a court shall be evaluated
in accordance with the standards applied to any other such disposition
for the purpose of determining eligibility. The commissioner shall
establish the standards for eligibility for medical assistance at one
hundred forty-three per cent of the benefit amount paid to a household
of equal size with no income under the temporary family assistance
program in the appropriate region of residence. In determining
eligibility, the commissioner shall not consider as income Aid and
Attendance pension benefits granted to a veteran, as defined in section
27-103, or the surviving spouse of such veteran. Except as provided in
section 17b-277 and section 17b-292, the medical assistance program
shall provide coverage to persons under the age of nineteen with
household income up to one hundred ninety-six per cent of the federal
poverty level without an asset limit and to persons under the age of
nineteen, who qualify for coverage under Section 1931 of the Social
Security Act, with household income not exceeding one hundred
ninety-six per cent of the federal poverty level without an asset limit,
and their parents and needy caretaker relatives, who qualify for
coverage under Section 1931 of the Social Security Act, with household
income not exceeding one hundred fifty-five two hundred one per cent
of the federal poverty level without an asset limit. Such levels shall be
based on the regional differences in such benefit amount, if applicable,
unless such levels based on regional differences are not in conformance
with federal law. Any income in excess of the applicable amounts shall
be applied as may be required by said federal law, and assistance shall
be granted for the balance of the cost of authorized medical assistance.
The Commissioner of Social Services shall provide applicants for
assistance under this section, at the time of application, with a written
statement advising them of (1) the effect of an assignment or transfer or
other disposition of property on eligibility for benefits or assistance, (2) the effect that having income that exceeds the limits prescribed in this subsection will have with respect to program eligibility, and (3) the availability of, and eligibility for, services provided by the Nurturing Families Network established pursuant to section 17b-751b. For coverage dates on or after January 1, 2014, the department shall use the modified adjusted gross income financial eligibility rules set forth in Section 1902(e)(14) of the Social Security Act and the implementing regulations to determine eligibility for HUSKY A, HUSKY B and HUSKY D applicants, as defined in section 17b-290. Persons who are determined ineligible for assistance pursuant to this section shall be provided a written statement notifying such persons of their ineligibility and advising such persons of their potential eligibility for one of the other insurance affordability programs as defined in 42 CFR 435.4.

Sec. 14. (NEW) (Effective July 1, 2021) The Labor Commissioner shall, within available appropriations, notify individuals applying for unemployment compensation benefits under chapter 567 of the general statutes that such individuals may be eligible for free or subsidized health coverage or other assistance or benefits, including, but not limited to, assistance under the supplemental nutrition assistance program. The commissioner shall refer such individuals to the exchange for the purpose of determining their eligibility for such coverage, assistance or benefits and, if such individuals are eligible for such coverage, assistance or benefits, enrolling such individuals in such coverage, assistance or benefits. For the purposes of this section, "exchange" and "qualified health plan" have the same meanings as provided in section 38a-1080 of the general statutes, as amended by this act.

This act shall take effect as follows and shall amend the following sections:

| Section 1 | July 1, 2021       | 3-123rrr |
| Sec. 2    | July 1, 2021       | New section |
| Sec. 3    | July 1, 2021       | 3-123vvv  |
| Sec. 4    | July 1, 2021       | New section |
Sec. 5 | July 1, 2021 | 38a-1080
Sec. 6 | July 1, 2021 | 38a-1084
Sec. 7 | July 1, 2021 | New section
Sec. 8 | July 1, 2021 | New section
Sec. 9 | July 1, 2021 | 19a-754a(a) and (b)
Sec. 10 | July 1, 2021 | New section
Sec. 11 | July 1, 2021 | 17b-597
Sec. 12 | July 1, 2021 | 17b-598
Sec. 13 | July 1, 2021 | 17b-261(a)
Sec. 14 | July 1, 2021 | New section

**Statement of Purpose:**
To: (1) Authorize the Comptroller to offer health coverage to plan participants and beneficiaries in this state under a multiemployer plan, nonprofit employers and their employees and small employers and their employees; (2) assess an annual fee against certain insurers, health care centers and exempt insurers; (3) require the Connecticut Health Insurance Exchange to (A) administer the "Connecticut Health Insurance Exchange account", (B) consult with the Office of Health Strategy to develop and, if approved, implement a plan to (i) establish a subsidiary, (ii) seek a state innovation waiver, and (iii) use the moneys deposited in said account for the purposes set forth in the plan, (C) consult with the Commissioner of Social Services to develop and, if approved, implement a methodology to determine eligibility for the working persons with disabilities program, and (D) determine whether certain individuals referred to the exchange by the Labor Commissioner are eligible for free or subsidized health coverage or other assistance or benefits and, if such individuals are eligible for such coverage, assistance or benefits, enroll such individuals in such coverage, assistance or benefits; (4) establish the "Connecticut Health Insurance Exchange account"; (5) require certain qualified health plans offered through the exchange to (A) provide coverage for certain benefits, (B) have a minimum actuarial value of at least seventy per cent, and (C) provide enrollees with access to the broadest provider network available under the qualified health plans offered by the health carrier through the exchange; (6) require the Office of Health Strategy to (A) annually determine, and disclose to the Office of Policy and Management, the amount of an annual assessment against certain insurers, health care centers and exempt insurers, and (B) develop, and submit to the joint standing committee of the General Assembly having cognizance of matters relating to insurance for approval, a plan for the exchange to (i) establish a subsidiary to create a marketplace for health
carriers to offer affordable health insurance coverage to persons who are ineligible for coverage under the qualified health plans offered through the exchange, (ii) seek a state innovation waiver to (I) reduce the cost of health insurance in this state, (II) make health insurance coverage available to persons in this state who are ineligible for coverage under a qualified health plan offered through the exchange, and (III) allow persons to receive coverage under the working persons with disabilities program through the exchange, and (iii) use the moneys deposited in the "Connecticut Health Insurance Exchange account" to (I) reduce the cost of qualified health plans offered through the exchange, (II) make coverage affordable for persons who are ineligible for coverage under a qualified health plan offered through the exchange, and (III) implement the state innovation waiver if the federal government issues such waiver; (7) (A) require the Commissioner of Social Services to amend the Medicaid state plan to develop a methodology to determine eligibility for the working persons with disabilities program and delegate authority to the exchange to determine eligibility for said program, and (B) expand eligibility for said program; (8) expand eligibility for medical assistance under the state's Medicaid program; and (9) require the Labor Commissioner to (A) notify applicants for unemployment compensation benefits that such applicants may be eligible for free or subsidized health coverage or other assistance or benefits, and (B) refer such applicants to the Connecticut Health Insurance Exchange.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]