General Assembly **_Raised Bill No. 842_**

January Session, 2021 LCO No. **2814**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING HEALTH INSURANCE AND HEALTH CARE IN CONNECTICUT.

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

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 Section 3-123rrr of the general statutes is repealed and the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

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

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

9 (2) "Health enhancement program" means the program established in
10 accordance with the provisions of the Revised State Employees
11 Bargaining Agent Coalition agreement, approved by the General
12 Assembly on August 22, 2011, for state employees, as amended by
13 stipulated agreements.

(3) "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.

[(2)] (4) "Nonstate public employee" means any employee or elected officer of a nonstate public employer.

[(3)] (5) "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.

(6) "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.

(7) "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.

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

[(5) "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.]

[(6)] (9) "Value-based insurance design" means health benefit designs

44 that lower or remove financial barriers to essential, high-value clinical
45 services.

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

50 Sec. 2. (NEW) (*Effective July 1, 2021*) (a) (1) Notwithstanding any
51 provision of title 38a of the general statutes, the Comptroller shall offer
52 to plan participants and beneficiaries in this state under a
53 multiemployer plan, nonprofit employers and their employees and
54 small employers and their employees coverage under the state
55 employee plan or another group hospitalization, medical, pharmacy
56 and surgical insurance plan developed by the Comptroller to provide
57 coverage for plan participants and beneficiaries in this state under a
58 multiemployer plan, nonprofit employers and their employees and
59 small employers and their employees. Plan participants and
60 beneficiaries in this state under a multiemployer plan, nonprofit
61 employers and their employees and small employers and their
62 employees receiving coverage provided pursuant to this section shall be
63 pooled with state employees and retirees under the state employee plan,
64 provided the administrator of the multiemployer plan, the nonprofit
65 employer or the small employer files an application with the
66 Comptroller for coverage pursuant to this section and the Comptroller
67 approves such application. The administrators of multiemployer plans,
68 nonprofit employers or small employers shall remit to the Comptroller
69 payments for coverage provided pursuant to this section. Such
70 payments shall be equal to the payments paid by the state for state
71 employees covered under the state employee plan, inclusive of any
72 premiums paid by state employees pursuant to the state employee plan,
73 except premium payments may be adjusted to reflect:

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

77 regulations adopted thereunder;

78 (B) Geographic area;

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

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

83 (ii) The sum of the premium payments for:

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

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

88 (D) Actuarially justified differences in:

89 (i) Plan design;

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

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

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

101 (2) Coverage provided pursuant to this section shall:

102 (A) Include the health enhancement program;

103 (B) Be consistent with value-based insurance design principles;

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

106 (D) Include coverage for:

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

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

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

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

123 (A) Three years for:

124 (i) Multiemployer plans; and

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

126 (B) One year for small employers.

127 (2) The administrator of each multiemployer plan, nonprofit
128 employer or small employer receiving coverage pursuant to this section
129 may apply to renew such coverage before the interval applicable to such
130 multiemployer plan, nonprofit employer or small employer under

131 subdivision (1) of this subsection expires.

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

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

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

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

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

152 (2) The Comptroller shall procure such services, including, but not
153 limited to, services necessary to ensure compliance with the Employee
154 Retirement Income Security Act of 1974, as amended from time to time,
155 and regulations adopted thereunder, that the Comptroller deems
156 necessary to administer coverage provided pursuant to this section. The
157 Comptroller shall make an assessment against the multiemployer plans,
158 nonprofit employers and small employers receiving coverage provided
159 pursuant to this section to recover the cost of such services. Such
160 assessment shall be made on a per employee, per month basis and shall
161 be considered an administrative fee.

162 (e) The Comptroller shall make reasonable efforts to minimize the
163 risk that coverage provided pursuant to this section poses to the state's
164 finances. In making such reasonable efforts, the Comptroller may,
165 among other things:

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

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

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

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

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

183 (B) Prevent the Comptroller from:

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

186 (ii) Offering plan designs or benefit coverage levels pursuant to this
187 section that differ from the plan designs and benefit coverage levels
188 offered to state employees, provided the Comptroller shall not offer any
189 coverage pursuant to this section that imposes a deductible that is
190 greater than the minimum deductible required by the Internal Revenue
191 Service for such coverage to qualify as a high deductible health plan, as

192 defined in Section 220(c)(2) or Section 223(c)(2) of the Internal Revenue
193 Code of 1986, or any subsequent corresponding internal revenue code
194 of the United States, as amended from time to time.

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

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

201 The Comptroller shall not offer coverage under the state employee
202 plan pursuant to sections 3-123rrr to 3-123uuu, inclusive, <u>as amended</u>
203 <u>by this act, or section 2 of this act</u> until the State Employees' Bargaining
204 Agent Coalition has provided its consent to the clerks of both houses of
205 the General Assembly to incorporate the terms of sections 3-123rrr to 3-
206 123uuu, inclusive, <u>as amended by this act, and section 2 of this act</u> into
207 its collective bargaining agreement.

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

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

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

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

218 (b) (1) Subject to the approval required under subsection (d) of section
219 10 of this act and, with respect to the matters for which the exchange
220 seeks a state innovation waiver pursuant to subparagraph (B) of
221 subdivision (28) of section 38a-1084 of the general statutes, issuance of

222 such state innovation waiver, the Office of Health Strategy, not later
223 than September 1, 2021, for plan year 2022 and annually thereafter for
224 the succeeding plan year, shall:

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

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

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

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

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

251 (3) Not later than November 1, 2021, and annually thereafter, the
252 commissioner shall determine the fee to be assessed for the succeeding

253 plan year against each insurer, health care center and exempt insurer
254 described in subdivision (1) of this subsection. Such fee shall be
255 calculated by multiplying the number of insured or enrolled lives
256 reported to the commissioner pursuant to subdivision (2) of this
257 subsection by a factor, determined annually by the commissioner, to
258 fully fund the amount determined by the Office of Health Strategy
259 under subparagraph (A) of subdivision (1) of subsection (b) of this
260 section, adjusted by subtracting, if the amount appropriated was more
261 than the amount expended, or by adding, if the amount expended was
262 more than the amount appropriated, the amount determined by the
263 Office of Health Strategy under subparagraph (A) of subdivision (1) of
264 subsection (b) of this section, less the amount of any federal pass-
265 through savings available pursuant to the waiver described in
266 subdivision (1) of subsection (b) of this section. The commissioner shall
267 determine the factor by dividing the adjusted amount by the total
268 number of insured or enrolled lives reported to the commissioner
269 pursuant to subdivision (2) of this subsection.

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

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

282 (5) Any insurer, health care center or exempt insurer that fails to file
283 the report required under subdivision (2) of this subsection shall pay a
284 late filing fee of one hundred dollars per day for each day from the date
285 such report was due. The commissioner may require an insurer, health

286 care center or exempt insurer subject to this subsection to produce any
287 records in its possession, and may require any other person to produce
288 any records in such other person's possession, that were used to prepare
289 such report for examination by the commissioner or the commissioner's
290 designee. If the commissioner determines there exists anything other
291 than a good faith discrepancy between the actual number of insured or
292 enrolled lives that should have been reported pursuant to subdivision
293 (2) of this subsection and the number actually reported, such insurer,
294 health care center or exempt insurer shall pay a civil penalty of not more
295 than fifteen thousand dollars for each report filed for which the
296 commissioner determines there is such a discrepancy.

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

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

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

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

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

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

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

315 (ii) Notify the insurer, health care center or exempt insurer of the

316 commissioner's determination under subparagraph (B)(i) of this
317 subdivision.

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

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

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

329 (e) If another state, territory or district of the United States, or a
330 foreign country, imposes on a Connecticut domiciled insurer, fraternal
331 benefit society, hospital service corporation, medical service
332 corporation, health care center or other domestic entity a retaliatory
333 charge for the fee imposed under this section, such domestic entity may,
334 not later than sixty days after receipt of notice of the imposition of the
335 retaliatory charge for such fee, appeal to the Insurance Commissioner
336 for a verification that the fee imposed under this section is subject to
337 retaliation by another state, territory or district of the United States, or a
338 foreign country. If the commissioner verifies, upon appeal to and
339 certification by the commissioner, that the fee imposed under this
340 section is the subject of a retaliatory tax, fee, assessment or other
341 obligation by another state, territory or district of the United States, or a
342 foreign country, such fee shall not be assessed against nondomestic
343 insurers and nondomestic exempt insurers pursuant to this section. Any
344 such domestic insurer, fraternal benefit society, hospital service
345 corporation, medical service corporation, health care center or other
346 entity aggrieved by the commissioner's decision issued under this
347 subsection may appeal therefrom in the same manner as provided

348 under section 38a-52 of the general statutes.

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

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

354 For purposes of sections 38a-1080 to 38a-1093, inclusive<u>, as amended</u>
355 <u>by this act, and sections 7 and 8 of this act</u>:

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

358 (2) "Commissioner" means the Insurance Commissioner;

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

361 (4) "Affordable Care Act" means the Patient Protection and
362 Affordable Care Act, P.L. 111-148, as amended by the Health Care and
363 Education Reconciliation Act, P.L. 111-152, as both may be amended
364 from time to time, and regulations adopted thereunder;

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

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

370 (i) Coverage of the type specified in subdivisions (5), (6), (7), (8), (9),
371 (14), (15) and (16) of section 38a-469 or any combination thereof;

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

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

375 (iv) Workers' compensation insurance;

376 (v) Automobile medical payment insurance;

377 (vi) Credit insurance;

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

379 (viii) Other similar insurance coverage specified in regulations issued
380 pursuant to the Health Insurance Portability and Accountability Act of
381 1996, P.L. 104-191, as amended from time to time, under which benefits
382 for health care services are secondary or incidental to other insurance
383 benefits.

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

387 (i) Limited scope dental or vision benefits;

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

390 (iii) Other similar, limited benefits specified in regulations issued
391 pursuant to the Health Insurance Portability and Accountability Act of
392 1996, P.L. 104-191, as amended from time to time;

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

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

403 whether benefits were also provided under any group health plan
404 maintained by the same plan sponsor;

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

407 (7) "Health carrier" means an insurance company, fraternal benefit
408 society, hospital service corporation, medical service corporation, health
409 care center or other entity subject to the insurance laws and regulations
410 of the state or the jurisdiction of the commissioner that contracts or
411 offers to contract to provide, deliver, pay for or reimburse any of the
412 costs of health care services;

413 (8) "Internal Revenue Code" means the Internal Revenue Code of
414 1986, or any subsequent corresponding internal revenue code of the
415 United States, as amended from time to time;

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

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

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

421 (12) "Qualified health plan" means a health benefit plan that has in
422 effect a certification that the plan meets the criteria for certification
423 described in Section 1311(c) of the Affordable Care Act and section 38a-
424 1086;

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

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

429 (15) "Small employer" has the same meaning as provided in section
430 38a-564.

431 Sec. 6. Section 38a-1084 of the general statutes is repealed and the
432 following is substituted in lieu thereof (*Effective July 1, 2021*):

433 The exchange shall:

434 (1) Administer the exchange for both qualified individuals and
435 qualified employers;

436 (2) Commission surveys of individuals, small employers and health
437 care providers on issues related to health care and health care coverage;

438 (3) Implement procedures for the certification, recertification and
439 decertification, consistent with guidelines developed by the Secretary
440 under Section 1311(c) of the Affordable Care Act, and section 38a-1086,
441 of health benefit plans as qualified health plans;

442 (4) Provide for the operation of a toll-free telephone hotline to
443 respond to requests for assistance;

444 (5) Provide for enrollment periods, as provided under Section
445 1311(c)(6) of the Affordable Care Act;

446 (6) Maintain an Internet web site through which enrollees and
447 prospective enrollees of qualified health plans may obtain standardized
448 comparative information on such plans including, but not limited to, the
449 enrollee satisfaction survey information under Section 1311(c)(4) of the
450 Affordable Care Act and any other information or tools to assist
451 enrollees and prospective enrollees evaluate qualified health plans
452 offered through the exchange;

453 (7) Publish the average costs of licensing, regulatory fees and any
454 other payments required by the exchange and the administrative costs
455 of the exchange, including information on moneys lost to waste, fraud
456 and abuse, on an Internet web site to educate individuals on such costs;

457 (8) On or before the open enrollment period for plan year 2017, assign
458 a rating to each qualified health plan offered through the exchange in
459 accordance with the criteria developed by the Secretary under Section

460 1311(c)(3) of the Affordable Care Act, and determine each qualified
461 health plan's level of coverage in accordance with regulations issued by
462 the Secretary under Section 1302(d)(2)(A) of the Affordable Care Act;

463 (9) Use a standardized format for presenting health benefit options in
464 the exchange, including the use of the uniform outline of coverage
465 established under Section 2715 of the Public Health Service Act, 42 USC
466 300gg-15, as amended from time to time;

467 (10) Inform individuals, in accordance with Section 1413 of the
468 Affordable Care Act, of eligibility requirements for the Medicaid
469 program under Title XIX of the Social Security Act, as amended from
470 time to time, the Children's Health Insurance Program (CHIP) under
471 Title XXI of the Social Security Act, as amended from time to time, or
472 any applicable state or local public program, and enroll an individual in
473 such program if the exchange determines, through screening of the
474 application by the exchange, that such individual is eligible for any such
475 program;

476 (11) Collaborate with the Department of Social Services, to the extent
477 possible, to allow an enrollee who loses premium tax credit eligibility
478 under Section 36B of the Internal Revenue Code and is eligible for
479 HUSKY A or any other state or local public program, to remain enrolled
480 in a qualified health plan;

481 (12) Establish and make available by electronic means a calculator to
482 determine the actual cost of coverage after application of any premium
483 tax credit under Section 36B of the Internal Revenue Code and any cost-
484 sharing reduction under Section 1402 of the Affordable Care Act;

485 (13) Establish a program for small employers through which
486 qualified employers may access coverage for their employees and that
487 shall enable any qualified employer to specify a level of coverage so that
488 any of its employees may enroll in any qualified health plan offered
489 through the exchange at the specified level of coverage;

490 (14) Offer enrollees and small employers the option of having the

491 exchange collect and administer premiums, including through
492 allocation of premiums among the various insurers and qualified health
493 plans chosen by individual employers;

494 (15) Grant a certification, subject to Section 1411 of the Affordable
495 Care Act, attesting that, for purposes of the individual responsibility
496 penalty under Section 5000A of the Internal Revenue Code, an
497 individual is exempt from the individual responsibility requirement or
498 from the penalty imposed by said Section 5000A because:

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

501 (B) The individual meets the requirements for any other such
502 exemption from the individual responsibility requirement or penalty;

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

505 (A) A list of the individuals granted a certification under subdivision
506 (15) of this section, including the name and taxpayer identification
507 number of each individual;

508 (B) The name and taxpayer identification number of each individual
509 who was an employee of an employer but who was determined to be
510 eligible for the premium tax credit under Section 36B of the Internal
511 Revenue Code because:

512 (i) The employer did not provide minimum essential health benefits
513 coverage; or

514 (ii) The employer provided the minimum essential coverage but it
515 was determined under Section 36B(c)(2)(C) of the Internal Revenue
516 Code to be unaffordable to the employee or not provide the required
517 minimum actuarial value; and

518 (C) The name and taxpayer identification number of:

519 (i) Each individual who notifies the exchange under Section
520 1411(b)(4) of the Affordable Care Act that such individual has changed
521 employers; and

522 (ii) Each individual who ceases coverage under a qualified health
523 plan during a plan year and the effective date of that cessation;

524 (17) Provide to each employer the name of each employee, as
525 described in subparagraph (B) of subdivision (16) of this section, of the
526 employer who ceases coverage under a qualified health plan during a
527 plan year and the effective date of the cessation;

528 (18) Perform duties required of, or delegated to, the exchange by the
529 Secretary or the Secretary of the Treasury of the United States related to
530 determining eligibility for premium tax credits, reduced cost-sharing or
531 individual responsibility requirement exemptions;

532 (19) Select entities qualified to serve as Navigators in accordance with
533 Section 1311(i) of the Affordable Care Act and award grants to enable
534 Navigators to:

535 (A) Conduct public education activities to raise awareness of the
536 availability of qualified health plans;

537 (B) Distribute fair and impartial information concerning enrollment
538 in qualified health plans and the availability of premium tax credits
539 under Section 36B of the Internal Revenue Code and cost-sharing
540 reductions under Section 1402 of the Affordable Care Act;

541 (C) Facilitate enrollment in qualified health plans;

542 (D) Provide referrals to the Office of the Healthcare Advocate or
543 health insurance ombudsman established under Section 2793 of the
544 Public Health Service Act, 42 USC 300gg-93, as amended from time to
545 time, or any other appropriate state agency or agencies, for any enrollee
546 with a grievance, complaint or question regarding the enrollee's health
547 benefit plan, coverage or a determination under that plan or coverage;
548 and

549 (E) Provide information in a manner that is culturally and
550 linguistically appropriate to the needs of the population being served by
551 the exchange;

552 (20) Review the rate of premium growth within and outside the
553 exchange and consider such information in developing
554 recommendations on whether to continue limiting qualified employer
555 status to small employers;

556 (21) Credit the amount, in accordance with Section 10108 of the
557 Affordable Care Act, of any free choice voucher to the monthly
558 premium of the plan in which a qualified employee is enrolled and
559 collect the amount credited from the offering employer;

560 (22) Consult with stakeholders relevant to carrying out the activities
561 required under sections 38a-1080 to 38a-1090, inclusive, as amended by
562 this act, including, but not limited to:

563 (A) Individuals who are knowledgeable about the health care system,
564 have background or experience in making informed decisions regarding
565 health, medical and scientific matters and are enrollees in qualified
566 health plans;

567 (B) Individuals and entities with experience in facilitating enrollment
568 in qualified health plans;

569 (C) Representatives of small employers and self-employed
570 individuals;

571 (D) The Department of Social Services; and

572 (E) Advocates for enrolling hard-to-reach populations;

573 (23) Meet the following financial integrity requirements:

574 (A) Keep an accurate accounting of all activities, receipts and
575 expenditures and annually submit to the Secretary, the Governor, the
576 Insurance Commissioner and the General Assembly a report concerning

577 such accountings;

578 (B) Fully cooperate with any investigation conducted by the Secretary
579 pursuant to the Secretary's authority under the Affordable Care Act and
580 allow the Secretary, in coordination with the Inspector General of the
581 United States Department of Health and Human Services, to:

582 (i) Investigate the affairs of the exchange;

583 (ii) Examine the properties and records of the exchange; and

584 (iii) Require periodic reports in relation to the activities undertaken
585 by the exchange; and

586 (C) Not use any funds in carrying out its activities under sections 38a-
587 1080 to 38a-1089, inclusive, <u>as amended by this act,</u> that are intended for
588 the administrative and operational expenses of the exchange, for staff
589 retreats, promotional giveaways, excessive executive compensation or
590 promotion of federal or state legislative and regulatory modifications;

591 (24) (A) Seek to include the most comprehensive health benefit plans
592 that offer high quality benefits at the most affordable price in the
593 exchange, (B) encourage health carriers to offer tiered health care
594 provider network plans that have different cost-sharing rates for
595 different health care provider tiers and reward enrollees for choosing
596 low-cost, high-quality health care providers by offering lower
597 copayments, deductibles or other out-of-pocket expenses, and (C) offer
598 any such tiered health care provider network plans through the
599 exchange; **[**and**]**

600 (25) Report at least annually to the General Assembly on the effect of
601 adverse selection on the operations of the exchange and make legislative
602 recommendations, if necessary, to reduce the negative impact from any
603 such adverse selection on the sustainability of the exchange, including
604 recommendations to ensure that regulation of insurers and health
605 benefit plans are similar for qualified health plans offered through the
606 exchange and health benefit plans offered outside the exchange. The

607 exchange shall evaluate whether adverse selection is occurring with
608 respect to health benefit plans that are grandfathered under the
609 Affordable Care Act, self-insured plans, plans sold through the
610 exchange and plans sold outside the exchange; **[.]**

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

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

616 (28) Subject to the approval required under subsection (d) of section
617 10 of this act:

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

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

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

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

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

633 (31) Determine whether individuals referred to the exchange by the
634 Labor Commissioner pursuant to section 14 of this act are eligible for
635 free or subsidized health coverage or other assistance or benefits,

636 including, but not limited to, assistance under the supplemental
637 nutrition assistance program, and, if such individuals are eligible for
638 such coverage, assistance or benefits, enroll such individuals in such
639 coverage, assistance or benefits.

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

647 Sec. 8. (NEW) (*Effective July 1, 2021*) (a) Notwithstanding any
648 provision of the general statutes and to the extent permitted by federal
649 law, each qualified health plan that is offered through the exchange at a
650 silver level of coverage for a plan year beginning on or after January 1,
651 2022, shall provide coverage for the following benefits:

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

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

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

663 (4) Blood pressure monitors for an enrollee who is diagnosed with
664 hypertension by a licensed health care provider who is acting within
665 such health care provider's scope of practice;

666 (5) Inhaled corticosteroids and peak flow meters for an enrollee who
667 is diagnosed with asthma by a licensed health care provider who is
668 acting within such health care provider's scope of practice;

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

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

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

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

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

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

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

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

693 Sec. 9. Subsections (a) and (b) of section 19a-754a of the general
694 statutes are repealed and the following is substituted in lieu thereof

695 (*Effective July 1, 2021*):

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

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

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

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

712 (3) Directing and overseeing the State Innovation Model Initiative
713 and related successor initiatives;

714 (4) (A) Coordinating the state's health information technology
715 initiatives, (B) seeking funding for and overseeing the planning,
716 implementation and development of policies and procedures for the
717 administration of the all-payer claims database program established
718 under section 19a-775a, (C) establishing and maintaining a consumer
719 health information Internet web site under section 19a-755b, and (D)
720 designating an unclassified individual from the office to perform the
721 duties of a health information technology officer as set forth in sections
722 17b-59f and 17b-59g;

723 (5) Directing and overseeing the Health Systems Planning Unit
724 established under section 19a-612 and all of its duties and

725 responsibilities as set forth in chapter 368z; **[**and**]**

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

730 <u>(7) Annually (A) determining the amount described in subparagraph</u>
731 <u>(A) of subdivision (1) of subsection (b) of section 4 of this act, and (B)</u>
732 <u>informing the Office of Policy and Management of such amount</u>
733 <u>pursuant to subparagraph (B) of subdivision (1) of subsection (b) of</u>
734 <u>section 4 of this act; and</u>

735 <u>(8) Developing a plan pursuant to subsection (b) of section 10 of this</u>
736 <u>act and submitting a report containing such plan pursuant to subsection</u>
737 <u>(c) of section 10 of this act.</u>

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

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

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

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

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

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

750 (b) The Office of Health Strategy shall, in consultation with the
751 exchange, develop a plan for the exchange to:

752 (1) Establish a subsidiary, in the manner set forth in section 38a-1093

753 of the general statutes, to create a marketplace for health carriers to offer
754 affordable health insurance coverage to persons who are ineligible for
755 coverage under the qualified health plans offered through the exchange;

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

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

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

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

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

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

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

779 (C) Implement the provisions of the state innovation waiver
780 described in subdivision (2) of this subsection if the federal government
781 issues such waiver for this state.

782 (c) Not later than August 1, 2021, the Office of Health Strategy shall
783 submit a report, in accordance with section 11-4a of the general statutes,
784 to the joint standing committee of the General Assembly having
785 cognizance of matters relating to insurance. Such report shall contain
786 the plan developed pursuant to subsection (b) of this section.

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

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

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

800 (b) The Commissioner of Social Services shall amend the Medicaid
801 state plan to develop, in consultation with the Connecticut Health
802 Insurance Exchange established pursuant to section 38a-1081, a
803 methodology to determine eligibility for the program established and
804 implemented by the commissioner pursuant to subsection (a) of this
805 section and allow persons specified in said subsection [(a) of this
806 section] to qualify for medical assistance regardless of assets. The
807 amendment shall include the following requirements: (1) That the
808 person be engaged in a substantial and reasonable work effort as
809 determined by the commissioner, or, if the amendment is approved, the
810 exchange, and as permitted by federal law; and [have an annual
811 adjusted gross income, as defined in Section 62 of the Internal Revenue
812 Code of 1986, or any subsequent corresponding internal revenue code
813 of the United States, as amended from time to time, of no more than

814 seventy-five thousand dollars per year; (2) a disregard of all countable
815 income up to two hundred per cent of the federal poverty level; (3) for
816 an unmarried person, an asset limit of ten thousand dollars, and for a
817 married couple, an asset limit of fifteen thousand dollars; (4) a disregard
818 of any retirement and medical savings accounts established pursuant to
819 26 USC 220 and held by either the person or the person's spouse; (5) a
820 disregard of any moneys in accounts designated by the person or the
821 person's spouse for the purpose of purchasing goods or services that
822 will increase the employability of such person, subject to approval by
823 the commissioner; (6) a disregard of spousal income solely for purposes
824 of determination of eligibility; and (7)**]** (2) a contribution of any
825 countable income of the person or the person's spouse which exceeds
826 two hundred per cent of the federal poverty level, as adjusted for the
827 appropriate family size, equal to ten per cent of the excess minus any
828 premiums paid from income for health insurance by any family
829 member, but which does not exceed the maximum contribution
830 allowable under Section 201(a)(3) of Public Law 106-170, as amended
831 from time to time.

832 (c) The Commissioner of Social Services shall (1) not later than
833 August 1, 2021, seek federal approval for a Medicaid state plan
834 amendment to implement the provisions of subsection (b) of this
835 section; and (2) assist the Connecticut Health Insurance Exchange,
836 established pursuant to section 38a-1081, to implement the policies and
837 procedures necessary to carry out the provisions of this section while
838 the commissioner is in the process of adopting such policies and
839 procedures in regulation form, provided notice of intent to adopt the
840 regulations is published **[**in the Connecticut Law Journal within**]** on the
841 Internet web site of the Department of Social Services and the
842 eRegulations System not later than twenty days after implementation.
843 The commissioner and the exchange shall define "countable income" for
844 purposes of subsection (b) of this section which shall take into account
845 impairment-related work expenses as defined in the Social Security Act.
846 Such policies and procedures shall be valid until the time final
847 regulations are effective.

848 Sec. 12. Section 17b-598 of the general statutes is repealed and the
849 following is substituted in lieu thereof (*Effective July 1, 2021*):

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

866 Sec. 13. Subsection (a) of section 17b-261 of the general statutes is
867 repealed and the following is substituted in lieu thereof (*Effective July 1,*
868 *2021*):

869 (a) Medical assistance shall be provided for any otherwise eligible
870 person whose income, including any available support from legally
871 liable relatives and the income of the person's spouse or dependent
872 child, is not more than one hundred forty-three per cent, pending
873 approval of a federal waiver applied for pursuant to subsection (e) of
874 this section, of the benefit amount paid to a person with no income
875 under the temporary family assistance program in the appropriate
876 region of residence and if such person is an institutionalized individual
877 as defined in Section 1917 of the Social Security Act, 42 USC 1396p(h)(3),
878 and has not made an assignment or transfer or other disposition of
879 property for less than fair market value for the purpose of establishing
880 eligibility for benefits or assistance under this section. Any such

881 disposition shall be treated in accordance with Section 1917(c) of the
882 Social Security Act, 42 USC 1396p(c). Any disposition of property made
883 on behalf of an applicant or recipient or the spouse of an applicant or
884 recipient by a guardian, conservator, person authorized to make such
885 disposition pursuant to a power of attorney or other person so
886 authorized by law shall be attributed to such applicant, recipient or
887 spouse. A disposition of property ordered by a court shall be evaluated
888 in accordance with the standards applied to any other such disposition
889 for the purpose of determining eligibility. The commissioner shall
890 establish the standards for eligibility for medical assistance at one
891 hundred forty-three per cent of the benefit amount paid to a household
892 of equal size with no income under the temporary family assistance
893 program in the appropriate region of residence. In determining
894 eligibility, the commissioner shall not consider as income Aid and
895 Attendance pension benefits granted to a veteran, as defined in section
896 27-103, or the surviving spouse of such veteran. Except as provided in
897 section 17b-277 and section 17b-292, the medical assistance program
898 shall provide coverage to persons under the age of nineteen with
899 household income up to one hundred ninety-six per cent of the federal
900 poverty level without an asset limit and to persons under the age of
901 nineteen, who qualify for coverage under Section 1931 of the Social
902 Security Act, with household income not exceeding one hundred
903 ninety-six per cent of the federal poverty level without an asset limit,
904 and their parents and needy caretaker relatives, who qualify for
905 coverage under Section 1931 of the Social Security Act, with household
906 income not exceeding **[**one hundred fifty-five**]** <u>two hundred one</u> per cent
907 of the federal poverty level without an asset limit. Such levels shall be
908 based on the regional differences in such benefit amount, if applicable,
909 unless such levels based on regional differences are not in conformance
910 with federal law. Any income in excess of the applicable amounts shall
911 be applied as may be required by said federal law, and assistance shall
912 be granted for the balance of the cost of authorized medical assistance.
913 The Commissioner of Social Services shall provide applicants for
914 assistance under this section, at the time of application, with a written
915 statement advising them of (1) the effect of an assignment or transfer or

916 other disposition of property on eligibility for benefits or assistance, (2)
917 the effect that having income that exceeds the limits prescribed in this
918 subsection will have with respect to program eligibility, and (3) the
919 availability of, and eligibility for, services provided by the Nurturing
920 Families Network established pursuant to section 17b-751b. For
921 coverage dates on or after January 1, 2014, the department shall use the
922 modified adjusted gross income financial eligibility rules set forth in
923 Section 1902(e)(14) of the Social Security Act and the implementing
924 regulations to determine eligibility for HUSKY A, HUSKY B and
925 HUSKY D applicants, as defined in section 17b-290. Persons who are
926 determined ineligible for assistance pursuant to this section shall be
927 provided a written statement notifying such persons of their ineligibility
928 and advising such persons of their potential eligibility for one of the
929 other insurance affordability programs as defined in 42 CFR 435.4.

930 Sec. 14. (NEW) (*Effective July 1, 2021*) The Labor Commissioner shall,
931 within available appropriations, notify individuals applying for
932 unemployment compensation benefits under chapter 567 of the general
933 statutes that such individuals may be eligible for free or subsidized
934 health coverage or other assistance or benefits, including, but not
935 limited to, assistance under the supplemental nutrition assistance
936 program. The commissioner shall refer such individuals to the exchange
937 for the purpose of determining their eligibility for such coverage,
938 assistance or benefits and, if such individuals are eligible for such
939 coverage, assistance or benefits, enrolling such individuals in such
940 coverage, assistance or benefits. For the purposes of this section,
941 "exchange" and "qualified health plan" have the same meanings as
942 provided in section 38a-1080 of the general statutes, as amended by this
943 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.]