

**Proposed Substitute
Bill No. 842**

January Session, 2021

LCO No. 5015

**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 Section 3-123rrr of the general statutes is repealed and the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, sections 2 and 3 of this
5 act:

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

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

15 (3) "Multiemployer plan" has the same meaning as provided in
16 Section 3 of the Employee Retirement Income Security Act of 1974, as
17 amended from time to time.

18 [(2)] (4) "Nonstate public employee" means any employee or elected
19 officer of a nonstate public employer.

20 [(3)] (5) "Nonstate public employer" means a municipality or other
21 political subdivision of the state, including a board of education, quasi-
22 public agency or public library. A municipality and a board of education
23 may be considered separate employers.

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

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

36 [(4)] (8) "State employee plan" means the group hospitalization,
37 medical, pharmacy and surgical insurance plan offered to state
38 employees and retirees pursuant to section 5-259.

39 [(5)] "Health enhancement program" means the program established
40 in accordance with the provisions of the Revised State Employees
41 Bargaining Agent Coalition agreement, approved by the General
42 Assembly on August 22, 2011, for state employees, as may be amended
43 by stipulated agreements.

44 (6)] (9) "Value-based insurance design" means health benefit designs
45 that lower or remove financial barriers to essential, high-value clinical
46 services.

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

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

74 (1) Premium payments may be adjusted to reflect:

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

79 (B) Geographic area;

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

82 (i) The sum of the premium payments for all covered family

83 members; or

84 (ii) The sum of the premium payments for all covered family
85 members who are twenty-one years of age or older and the eldest three
86 covered dependents who are younger than twenty-one years of age;

87 (D) Actuarially justified differences in:

88 (i) Plan design;

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

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

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

100 (2) Such payments shall be adjusted to include:

101 (A) The fee assessed by the Comptroller against multiemployer plans,
102 nonprofit employers and small employers pursuant to section 3 of this
103 act;

104 (B) The health and welfare fee assessed by the Insurance
105 Commissioner against multiemployer plans, nonprofit employers and
106 small employers pursuant to section 19a-7j of the general statutes, as
107 amended by this act, which the Comptroller shall annually collect from
108 the administrators of multiemployer plans, nonprofit employers and
109 small employers, and pay to the Insurance Commissioner, pursuant to
110 section 19a-7j of the general statutes, as amended by this act;

111 (C) The public health fee assessed by the Insurance Commissioner
112 against multiemployer plans, nonprofit employers and small employers
113 pursuant to section 19a-7p of the general statutes, as amended by this
114 act, which the Comptroller shall annually collect from the
115 administrators of multiemployer plans, nonprofit employers and small
116 employers, and pay to the Insurance Commissioner, pursuant to section
117 19a-7p of the general statutes, as amended by this act;

118 (D) The administrative fee assessed by the Comptroller pursuant to
119 subdivision (4) of subsection (c) of this section; and

120 (E) Any risk fund fee assessed by the Comptroller pursuant to
121 subdivision (2) of subsection (d) of this section; and

122 (3) Such payments may be adjusted to include a general
123 administrative fee assessed by the Comptroller against multiemployer
124 plans, nonprofit employers and small employers receiving coverage
125 provided by the Comptroller pursuant to this section which, if assessed,
126 shall be calculated on a per member, per month basis and may include
127 brokers' fees.

128 (b) (1) The coverage provided by the Comptroller pursuant to this
129 section shall:

130 (A) Be available to all plan participants and beneficiaries in this state
131 under a multiemployer plan, nonprofit employers in this state, their
132 employees and their employees' dependents and small employers in
133 this state, their employees and their employees' dependents regardless
134 of age, gender, health status or any other factor that might be predictive
135 of health care service usage;

136 (B) Include the health enhancement program;

137 (C) Be consistent with value-based insurance design principles;

138 (D) Be approved by the Health Care Cost Containment Committee
139 during a public meeting of the Health Care Cost Containment
140 Committee;

141 (E) Include coverage for:

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

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

152 (F) Include a process that enables entities that conduct independent
153 external reviews of adverse determinations and final adverse
154 determinations, as both terms are defined in section 38a-591a of the
155 general statutes, to review determinations made for benefits covered
156 pursuant to this section that are equivalent to adverse determinations
157 and final adverse determinations; and

158 (G) Enable plan participants and beneficiaries in this state under a
159 multiemployer plan, nonprofit employers in this state, their employees
160 and their employees' dependents and small employers in this state, their
161 employees and their employees' dependents receiving coverage
162 provided by the Comptroller pursuant to this section to access
163 assistance offered by the Office of the Healthcare Advocate under
164 section 38a-1041 of the general statutes, as amended by this act.

165 (2) (A) The Comptroller shall provide coverage pursuant to this
166 section for intervals lasting not less than:

167 (i) Three years for:

168 (I) Multiemployer plans; and

169 (II) Nonprofit employers that are not small employers; or

170 (ii) One year for small employers.

171 (B) The administrator of each multiemployer plan, nonprofit
172 employer or small employer receiving coverage provided by the
173 Comptroller pursuant to this section may apply to renew such coverage
174 before the interval applicable to such multiemployer plan, nonprofit
175 employer or small employer under subparagraph (A) of this subdivision
176 expires.

177 (3) The Comptroller shall require each administrator of a
178 multiemployer plan, nonprofit employer in this state and small
179 employer in this state receiving coverage provided by the Comptroller
180 pursuant to this section to offer such coverage to all of such
181 multiemployer plan's participants and beneficiaries in this state,
182 nonprofit employer's employees and their employees' dependents and
183 small employer's employees and their employees' dependents who are
184 eligible for health coverage. The administrator of such multiemployer
185 plan, nonprofit employer or small employer shall not offer coverage
186 under this section in addition to, or in conjunction with, any other health
187 coverage option, except active employees and retirees may be treated as
188 independent groups for the purposes of this subdivision.

189 (c) (1) The Comptroller shall develop and establish:

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

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

196 (C) Accounting procedures to track the premium payments paid by,
197 and claims paid for, multiemployer plans, nonprofit employers and
198 small employers receiving coverage provided by the Comptroller
199 pursuant to this section; and

200 (D) Procedures to collect demographic data, including, but not
201 limited to, self-reported ethnic and racial data, concerning the plan
202 participants and beneficiaries in this state under a multiemployer plan,
203 nonprofit employers in this state, their employees and their employees'
204 dependents and small employers in this state, their employees and their
205 employees' dependents receiving coverage provided by the
206 Comptroller pursuant to this section. Such procedures shall, at a
207 minimum, utilize standardized categories developed by the Office of
208 Health Strategy pursuant to subdivision (9) of subsection (b) of section
209 19a-754a of the general statutes, as amended by this act, include an
210 "other" category and allow an individual who is self-reporting ethnic or
211 racial data to write in such individual's ethnicity or race, and select
212 multiple ethnicities and races, on any form provided by the Comptroller
213 to collect such ethnic or racial data. Not later than November 1, 2022,
214 and annually thereafter, the Comptroller shall submit a report to the
215 joint standing committee of the General Assembly having cognizance of
216 matters relating to insurance, in accordance with the provisions of
217 section 11-4a of the general statutes, disclosing, in the aggregate, the
218 demographic data collected using the procedures developed and
219 established by the Comptroller pursuant to this subparagraph during
220 the immediately preceding fiscal year.

221 (2) The Comptroller shall:

222 (A) Retain an independent actuarial firm to:

223 (i) Set premium payments for coverage provided by the Comptroller
224 pursuant to this section that satisfy the requirements established in this
225 section and actuarial best practices; and

226 (ii) Not later than November 1, 2022, and annually thereafter,
227 examine the books and records maintained by the Comptroller in
228 providing coverage pursuant to this section, and any person engaged
229 by the Comptroller to provide services to the Comptroller in connection
230 with providing such coverage, and prepare a report concerning such
231 examination, which shall disclose:

232 (I) The number of multiemployer plans, nonprofit employers and
233 small employers that received coverage provided by the Comptroller
234 pursuant to this section during the immediately preceding fiscal year;

235 (II) The number of multiemployer plan participants and beneficiaries
236 in this state, nonprofit employers' employees and their employees'
237 dependents and small employers' employees and their employees'
238 dependents who received coverage provided by the Comptroller
239 pursuant to this section during the immediately preceding fiscal year;

240 (III) The aggregate amount of premiums collected, claims paid and
241 administrative costs incurred by the Comptroller in providing coverage
242 pursuant to this section for the immediately preceding fiscal year;

243 (IV) The most recent medical loss ratio available for coverage
244 provided by the Comptroller pursuant to this section;

245 (V) The balance of the account in which the Comptroller deposited
246 premiums, and from which the Comptroller paid claims, for coverage
247 provided by the Comptroller pursuant to this section at the beginning
248 and the end of the immediately preceding fiscal year, and a comparison
249 of such balance to the amount that the independent actuarial firm
250 recommends that the Comptroller maintain as a reserve for such
251 coverage;

252 (VI) A description, and the cost, of each risk mitigation strategy that
253 the Comptroller employed for the immediately preceding fiscal year to
254 minimize the risk that coverage provided by the Comptroller pursuant
255 to this section for such fiscal year poses to this state's finances; and

256 (VII) The independent actuarial firm's recommendations, if any, to
257 improve or update the risk mitigation strategies employed by the
258 Comptroller to minimize the risk that coverage provided by the
259 Comptroller pursuant to this section poses to this state's finances; and

260 (B) Such services, including, but not limited to, any services to ensure
261 compliance with the Employee Retirement Income Security Act of 1974,

262 as amended from time to time, and regulations adopted thereunder, that
263 the Comptroller deems necessary to administer coverage provided by
264 the Comptroller pursuant to this section.

265 (3) The independent actuarial firm retained by the Comptroller
266 pursuant to subparagraph (A) of subdivision (2) of this subsection shall,
267 not later than November 1, 2022, and annually thereafter, submit the
268 report that the independent actuarial firm prepared pursuant to
269 subparagraph (A)(ii) of subdivision (2) of this subsection for the
270 immediately preceding fiscal year to the Comptroller and the Office of
271 Policy and Management and to the joint standing committees of the
272 General Assembly having cognizance of matters relating to
273 appropriations and insurance in accordance with the provisions of
274 section 11-4a of the general statutes.

275 (4) The Comptroller shall assess an administrative fee on a per
276 member, per month basis against the multiemployer plans, nonprofit
277 employers and small employers receiving coverage provided by the
278 Comptroller pursuant to this section to recover the cost of the services
279 described in subdivisions (2) and (3) of this subsection.

280 (d) The Comptroller shall make reasonable efforts to minimize the
281 risk that coverage provided by the Comptroller pursuant to this section
282 poses to this state's finances. In making such reasonable efforts, the
283 Comptroller shall, at a minimum:

284 (1) Purchase:

285 (A) An aggregate stop-loss insurance policy for all multiemployer
286 plans, nonprofit employers and small employers receiving coverage
287 provided by the Comptroller pursuant to this section; or

288 (B) A stop-loss insurance policy for each individual multiemployer
289 plan, nonprofit employer or small employer receiving coverage
290 provided by the Comptroller pursuant to this section; and

291 (2) Establish a risk fund to pay claims that exceed the premiums

292 collected for a multiemployer plan, nonprofit employer or small
293 employer receiving coverage provided by the Comptroller pursuant to
294 this section, fund such risk fund through a risk fund fee assessed by the
295 Comptroller against such multiemployer plan, nonprofit employer or
296 small employer and establish operating procedures for use of such fund.

297 (e) (1) Not later than October 15, 2021, and annually thereafter, the
298 Comptroller shall prepare, in consultation with the Commissioner of
299 Public Health and the Insurance Commissioner, a report card for the
300 coverage offered by the Comptroller pursuant to this section. The report
301 card shall enable the administrators of multiemployer plans, nonprofit
302 employers and small employers that are eligible for the coverage offered
303 by the Comptroller pursuant to this section to compare such coverage
304 to private group health coverage that is available to such multiemployer
305 plans, nonprofit employers and small employers in this state to the same
306 extent that the consumer report card developed and distributed by the
307 Insurance Commissioner pursuant to section 38a-478l of the general
308 statutes permits consumer comparison across managed care
309 organizations.

310 (2) Each report card prepared by the Comptroller pursuant to
311 subdivision (1) of this subsection shall disclose:

312 (A) The medical loss ratio for:

313 (i) Coverage provided under the state employee plan pursuant to this
314 section if the Comptroller offers coverage under the state employee plan
315 pursuant to this section; or

316 (ii) Any group hospitalization, medical, pharmacy and surgical
317 insurance plan developed and offered by the Comptroller pursuant to
318 this section;

319 (B) The medical loss ratio for private group health coverage that is
320 available to the multiemployer plans, nonprofit employers and small
321 employers that are eligible for the coverage offered by the Comptroller
322 pursuant to this section; and

323 (C) Any other information that the Comptroller deems relevant for
324 the purposes of this subsection.

325 (3) The Comptroller shall prominently display a link to each report
326 card prepared pursuant to subdivision (1) of this subsection on the
327 Comptroller's Internet web site.

328 (f) Any administrator of a multiemployer plan, nonprofit employer
329 or small employer that files an application with the Comptroller for the
330 coverage offered by the Comptroller pursuant to this section may
331 submit a request to the Comptroller, in a form and manner prescribed
332 by the Comptroller, for a provider disruption report. The Comptroller
333 shall provide the provider disruption report to such administrator,
334 nonprofit employer or small employer not later than thirty days after
335 such administrator, nonprofit employer or small employer submits such
336 request to the Comptroller.

337 (g) (1) Nothing in this section shall be construed to preclude the
338 Comptroller from:

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

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

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

354 (h) The Comptroller may adopt regulations, in accordance with
355 chapter 54 of the general statutes, to carry out the purposes of this
356 section.

357 Sec. 3. (NEW) (*Effective July 1, 2021*) (a) For each fiscal year beginning
358 on or after July 1, 2021, the Comptroller shall assess a fee against all
359 multiemployer plans, nonprofit employers and small employers
360 receiving coverage provided by the Comptroller pursuant to section 2
361 of this act, and the administrator of each such multiemployer plan and
362 each such nonprofit employer and small employer shall pay such
363 assessment to the Comptroller pursuant to this section for deposit in the
364 Connecticut Health Insurance Exchange account established under
365 section 13 of this act.

366 (b) Not later than July 15, 2021, and annually thereafter, the
367 Comptroller shall consult with the Insurance Commissioner to
368 determine the aggregate amount of the assessments due from the
369 multiemployer plans, nonprofit employers and small employers
370 receiving coverage provided by the Comptroller pursuant to section 2
371 of this act for the then current fiscal year. The aggregate amount of
372 assessments due for any fiscal year shall be equal to the amount that
373 would be due from the Comptroller for such fiscal year if the
374 Comptroller were a domestic insurance company, and the coverage
375 provided by the Comptroller pursuant to section 2 of this act were fully
376 insured group health insurance coverage, under sections 38a-47 and
377 38a-48 of the general statutes during such fiscal year.

378 (c) Not later than July 31, 2021, and annually thereafter, the
379 Comptroller shall render to the administrator of each multiemployer
380 plan and each nonprofit employer and small employer that is liable for
381 the fee assessed by the Comptroller pursuant to subsection (a) of this
382 section the proposed assessment against such multiemployer plan,
383 nonprofit employer or small employer in the amount described in
384 subsection (b) of this section.

385 (d) On or before September first, annually, for each fiscal year

386 beginning on or after July 1, 2021, the Comptroller, after receiving any
387 objections to the proposed assessments made by the Comptroller
388 pursuant to this section and making such adjustments as in the
389 Comptroller's opinion may be indicated, shall assess against each
390 multiemployer plan, nonprofit employer or small employer an amount
391 equal to the proposed assessment as so adjusted. The administrator of
392 each multiemployer plan and each such nonprofit employer and small
393 employer shall pay to the Comptroller, on or before the following
394 December thirty-first and March thirty-first, annually, the proposed
395 assessment due from such multiemployer plan, nonprofit employer or
396 small employer in two equal installments.

397 (e) The administrator of any multiemployer plan, nonprofit employer
398 or small employer aggrieved because of a fee assessed by the
399 Comptroller pursuant to this section may appeal therefrom in
400 accordance with the provisions of section 38a-52 of the general statutes,
401 as amended by this act.

402 (f) If the administrator of a multiemployer plan, or a nonprofit
403 employer or small employer, that is liable for the fee assessed by the
404 Comptroller pursuant to this section fails to pay an assessment when
405 due under this section, the Comptroller shall add a penalty of twenty-
406 five dollars to such fee, and interest at the rate of six per cent per annum
407 shall be paid thereafter on such assessment and penalty, until such
408 assessment and penalty are paid.

409 (g) The Comptroller shall deposit all payments made pursuant to this
410 section in the Connecticut Health Insurance Exchange account
411 established under section 13 of this act.

412 (h) The Comptroller may adopt regulations, in accordance with
413 chapter 54 of the general statutes, to carry out the purposes of this
414 section.

415 Sec. 4. Section 3-123vvv of the general statutes is repealed and the
416 following is substituted in lieu thereof (*Effective July 1, 2021*):

417 The Comptroller shall not offer coverage under the state employee
418 plan pursuant to sections 3-123rrr to 3-123uuu, inclusive, as amended
419 by this act, or section 2 of this act until the State Employees' Bargaining
420 Agent Coalition has provided its consent to the clerks of both houses of
421 the General Assembly to incorporate the terms of sections 3-123rrr to 3-
422 123uuu, inclusive, as amended by this act, and section 2 of this act into
423 its collective bargaining agreement.

424 Sec. 5. Section 19a-7j of the general statutes is repealed and the
425 following is substituted in lieu thereof (*Effective July 1, 2021*):

426 (a) As used in this section:

427 (1) "Exempt insurer" means a domestic insurer that administers self-
428 insured health benefit plans and is exempt from third-party
429 administrator licensure under subparagraph (C) of subdivision (11) of
430 section 38a-720 and section 38a-720a;

431 (2) "Health insurance" means health insurance providing coverage of
432 the types specified in subdivisions (1), (2), (4), (11) and (12) of section
433 38a-469;

434 (3) "Multiemployer plan" has the same meaning as provided in
435 Section 3 of the Employee Retirement Income Security Act of 1974, as
436 amended from time to time;

437 (4) "Nonprofit employer" has the same meaning as provided in
438 section 3-123rrr, as amended by this act; and

439 (5) "Small employer" has the same meaning as provided in section 3-
440 123rrr, as amended by this act.

441 (b) Not later than September first, annually, the Secretary of the Office
442 of Policy and Management, in consultation with the Commissioner of
443 Public Health, shall:

444 (1) [determine] Determine the amount appropriated for the following
445 purposes:

446 (A) To purchase, store and distribute vaccines for routine
447 immunizations included in the schedule for active immunization
448 required by section 19a-7f;

449 (B) ~~[to]~~ To purchase, store and distribute:

450 (i) ~~[vaccines]~~ Vaccines to prevent hepatitis A and B in persons of all
451 ages, as recommended by the schedule for immunizations published by
452 the National Advisory Committee for Immunization Practices; ~~[,]~~

453 (ii) ~~[antibiotics]~~ Antibiotics necessary for; ~~[the]~~

454 (I) The treatment of tuberculosis and biologics; and ~~[antibiotics]~~
455 necessary for the]

456 (II) The detection and treatment of tuberculosis infections; ~~[,]~~ and

457 (iii) ~~[antibiotics]~~ Antibiotics to support treatment of patients in
458 communicable disease control clinics, as defined in section 19a-216a;

459 (C) ~~[to]~~ To administer the immunization program described in
460 section 19a-7f; and

461 (D) ~~[to]~~ To provide services needed to collect up-to-date information
462 on childhood immunizations for all children enrolled in Medicaid who
463 reach two years of age during the year preceding the current fiscal year,
464 to incorporate such information into the childhood immunization
465 registry, as defined in section 19a-7h; ~~[,]~~

466 (2) ~~[calculate]~~ Calculate the difference between the amount expended
467 in the prior fiscal year for the purposes set forth in subdivision (1) of this
468 subsection and the amount of the appropriation used for the purpose of
469 the health and welfare fee established in subparagraph (A) of
470 subdivision [(2)] (1) of subsection [(b)] (c) of this section in that same
471 year; ~~[,]~~ and

472 (3) ~~[inform]~~ Inform the Insurance Commissioner of such amounts.

473 [(b) (1) As used in this subsection, (A) "health insurance" means

474 health insurance of the types specified in subdivisions (1), (2), (4), (11)
475 and (12) of section 38a-469, and (B) "exempt insurer" means a domestic
476 insurer that administers self-insured health benefit plans and is exempt
477 from third-party administrator licensure under subparagraph (C) of
478 subdivision (11) of section 38a-720 and section 38a-720a.]

479 [(2)] (c) (1) (A) Each domestic insurer [or] and domestic health care
480 center doing health insurance business in this state shall annually pay
481 to the Insurance Commissioner, for deposit in the Insurance Fund
482 established under section 38a-52a, a health and welfare fee assessed by
483 the Insurance Commissioner pursuant to this section.

484 (B) Each third-party administrator licensed pursuant to section 38a-
485 720a that provides administrative services for self-insured health benefit
486 plans and each exempt insurer shall, on behalf of the self-insured health
487 benefit plans for which such third-party administrator or exempt
488 insurer provides administrative services, annually pay to the Insurance
489 Commissioner, for deposit in the Insurance Fund established under
490 section 38a-52a, a health and welfare fee assessed by the Insurance
491 Commissioner pursuant to this section.

492 (C) The Comptroller shall, on behalf of each multiemployer plan,
493 nonprofit employer and small employer receiving coverage provided
494 by the Comptroller pursuant to section 2 of this act, annually pay to the
495 Insurance Commissioner, for deposit in the Insurance Fund established
496 under section 38a-52a, a health and welfare fee assessed by the
497 Insurance Commissioner pursuant to this section.

498 [(3)] (2) Not later than September first, annually: [, each such]

499 (A) Each domestic insurer [,] and domestic health care center
500 described in subparagraph (A) of subdivision (1) of this subsection, and
501 each third-party administrator and exempt insurer described in
502 subparagraph (B) of subdivision (1) of this subsection, shall report to the
503 Insurance Commissioner, on a form designated by [said commissioner]
504 the Insurance Commissioner, the number of insured or enrolled lives in
505 this state as of the May first immediately preceding for which such

506 domestic insurer, domestic health care center, third-party administrator
507 or exempt insurer [is] was providing health insurance or administering
508 a self-insured health benefit plan [that provides] providing coverage of
509 the types specified in subdivisions (1), (2), (4), (11) and (12) of section
510 38a-469, [. Such number shall not include] excluding any lives enrolled
511 in Medicare, any medical assistance program administered by the
512 Department of Social Services, workers' compensation insurance or
513 Medicare Part C plans; and

514 (B) The Comptroller shall report to the Insurance Commissioner, in
515 the form and manner prescribed by the Insurance Commissioner:

516 (i) For each multiemployer plan described in subparagraph (C) of
517 subdivision (1) of this subsection, the number of such multiemployer
518 plan's plan participants and beneficiaries in this state for whom the
519 Comptroller was providing coverage pursuant to section 2 of this act as
520 of the May first immediately preceding;

521 (ii) For each nonprofit employer described in subparagraph (C) of
522 subdivision (1) of this subsection, the number of such nonprofit
523 employer's employees and their dependents in this state for whom the
524 Comptroller was providing coverage pursuant to section 2 of this act as
525 of the May first immediately preceding; and

526 (iii) For each small employer described in subparagraph (C) of
527 subdivision (1) of this subsection, the number of such small employer's
528 employees and their dependents in this state for whom the Comptroller
529 was providing coverage pursuant to section 2 of this act as of the May
530 first immediately preceding.

531 [(4)] (3) Not later than November first, annually, the Insurance
532 Commissioner shall determine the fee to be assessed for the current
533 fiscal year against each [such] domestic insurer [,] and domestic health
534 care center described in subparagraph (A) of subdivision (1) of this
535 subsection, third-party administrator and exempt insurer described in
536 subparagraph (B) of subdivision (1) of this subsection and
537 multiemployer plan, nonprofit employer and small employer described

538 in subparagraph (C) of subdivision (1) of this subsection. Such fee shall
539 be calculated by multiplying the number of lives reported to [said
540 commissioner] the Insurance Commissioner pursuant to subparagraph
541 (A) of subdivision [(3)] (2) of this subsection, and the number of plan
542 participants, beneficiaries, employees and dependents reported to the
543 Insurance Commissioner pursuant to subparagraph (B) of subdivision
544 (2) of this subsection, by a factor, determined annually by [said
545 commissioner] the Insurance Commissioner as set forth in this
546 subdivision, to fully fund the amount determined under subdivision (1)
547 of subsection [(a)] (b) of this section, adjusted for a health and welfare
548 fee, by subtracting, if the amount appropriated was more than the
549 amount expended or by adding, if the amount expended was more than
550 the amount appropriated, the amount calculated under subdivision (2)
551 of subsection [(a)] (b) of this section. The Insurance Commissioner shall
552 determine the factor by dividing the adjusted amount by the sum of the
553 total number of lives reported to [said commissioner] the Insurance
554 Commissioner pursuant to subparagraph (A) of subdivision [(3)] (2) of
555 this subsection and the number of plan participants, beneficiaries,
556 employees and dependents reported to the Insurance Commissioner
557 pursuant to subparagraph (B) of subdivision (2) of this subsection.

558 [(5)] (4) (A) Not later than December first, annually, the Insurance
559 Commissioner shall submit a statement to each [such] domestic insurer
560 [,] and domestic health care center [,] described in subparagraph (A) of
561 subdivision (1) of this subsection, each third-party administrator and
562 exempt insurer described in subparagraph (B) of subdivision (1) of this
563 subsection and the Comptroller for each multiemployer plan, nonprofit
564 employer or small employer described in subparagraph (C) of
565 subdivision (1) of this subsection that includes the proposed fee,
566 identified on such statement as the "Health and Welfare fee", for [the]
567 such domestic insurer, domestic health care center, third-party
568 administrator, [or] exempt insurer, multiemployer plan, nonprofit
569 employer or small employer calculated in accordance with this
570 subsection. [Each] The Comptroller shall collect such fee from each such
571 multiemployer plan, nonprofit employer and small employer described

572 in subparagraph (C) of subdivision (1) of this subsection and pay such
573 fee to the Insurance Commissioner, and each such domestic insurer,
574 domestic health care center, third-party administrator and exempt
575 insurer shall pay such fee to the Insurance Commissioner, not later than
576 February first, annually.

577 (B) Any [such] domestic insurer [,] or domestic health care center
578 described in subparagraph (A) of subdivision (1) of this subsection,
579 third-party administrator or exempt insurer described in subparagraph
580 (B) of subdivision (1) of this subsection or the administrator of a
581 multiemployer plan, a nonprofit employer or a small employer
582 described in subparagraph (C) of subdivision (1) of this subsection that
583 is aggrieved by an assessment levied under this subsection may appeal
584 therefrom in the same manner as provided for appeals under section
585 38a-52, as amended by this act.

586 ~~[(6)]~~ (5) Any domestic insurer, domestic health care center, third-
587 party administrator or exempt insurer that fails to file the report
588 required under subparagraph (A) of subdivision [(3)] (2) of this
589 subsection shall pay a late filing fee of one hundred dollars per day for
590 each day from the date such report was due. The Insurance
591 Commissioner may require [an] a domestic insurer, domestic health
592 care center, third-party administrator or exempt insurer subject to this
593 subsection to produce the records in its possession, and may require any
594 other person to produce the records in such person's possession, that
595 were used to prepare such report, for [said commissioner's] the
596 Insurance Commissioner's or [said commissioner's] the Insurance
597 Commissioner's designee's examination. If [said commissioner] the
598 Insurance Commissioner determines there is other than a good faith
599 discrepancy between the actual number of insured or enrolled lives that
600 should have been reported under subparagraph (A) of subdivision [(3)]
601 (2) of this subsection and the number actually reported, such domestic
602 insurer, domestic health care center, third-party administrator or
603 exempt insurer shall pay a civil penalty of not more than fifteen
604 thousand dollars for each report filed for which [said commissioner] the
605 Insurance Commissioner determines there is such a discrepancy.

606 [(7)] (6) (A) The Insurance Commissioner shall apply an overpayment
607 of the health and welfare fee by [an] a domestic insurer, domestic health
608 care center, third-party administrator or exempt insurer, or by the
609 Comptroller on behalf of a multiemployer plan, nonprofit employer or
610 small employer described in subparagraph (C) of subdivision (1) of this
611 subsection, for any fiscal year as a credit against the health and welfare
612 fee due from such domestic insurer, domestic health care center, third-
613 party administrator, [or] exempt insurer, multiemployer plan, nonprofit
614 employer or small employer for the succeeding fiscal year, subject to an
615 adjustment under subdivision [(4)] (3) of this subsection: [, if:]

616 (i) [The] If the amount of the overpayment exceeds five thousand
617 dollars; and

618 (ii) If, on or before June first of the calendar year of the overpayment,
619 [the] such domestic insurer, domestic health care center, third-party
620 administrator, [or] exempt insurer, multiemployer plan, nonprofit
621 employer or small employer:

622 (I) [notifies] Notifies the [commissioner] Insurance Commissioner of
623 the amount of the overpayment; [,] and

624 (II) [provides] Provides the [commissioner] Insurance Commissioner
625 with evidence sufficient to prove the amount of the overpayment.

626 (B) Not later than ninety days following receipt of notice and
627 supporting evidence under subparagraph (A) of this subdivision, the
628 [commissioner] Insurance Commissioner shall:

629 (i) [determine] Determine whether the domestic insurer, domestic
630 health care center, third-party administrator, [or] exempt insurer,
631 multiemployer plan, nonprofit employer or small employer made an
632 overpayment; [,] and

633 (ii) [notify] Notify the domestic insurer, domestic health care center,
634 third-party administrator, [or] exempt insurer, multiemployer plan,
635 nonprofit employer or small employer of such determination.

636 (C) Failure of [an] a domestic insurer, domestic health care center,
637 third-party administrator, [or] exempt insurer, multiemployer plan,
638 nonprofit employer or small employer to notify the commissioner of the
639 amount of an overpayment within the time prescribed in subparagraph
640 (A) of this subdivision constitutes a waiver of any demand of the
641 domestic insurer, domestic health care center, third-party
642 administrator, [or] exempt insurer, multiemployer plan, nonprofit
643 employer or small employer against the state on account of such
644 overpayment.

645 (D) Nothing in this subdivision shall be construed to prohibit or limit
646 the right of [an] a domestic insurer, domestic health care center, third-
647 party administrator, [or] exempt insurer, multiemployer plan, nonprofit
648 employer or small employer to appeal pursuant to subparagraph (B) of
649 subdivision [(5)] (4) of this [section] subsection.

650 Sec. 6. Section 19a-7p of the general statutes is repealed and the
651 following is substituted in lieu thereof (*Effective July 1, 2021*):

652 (a) As used in this section:

653 (1) "Health care center" has the same meaning as provided in section
654 38a-175;

655 (2) "Health insurance" means health insurance providing coverage of
656 the types specified in subdivisions (1), (2), (4), (11) and (12) of section
657 38a-469;

658 (3) "Multiemployer plan" has the same meaning as provided in
659 Section 3 of the Employee Retirement Income Security Act of 1974, as
660 amended from time to time;

661 (4) "Nonprofit employer" has the same meaning as provided in
662 section 3-123rrr, as amended by this act; and

663 (5) "Small employer" has the same meaning as provided in section 3-
664 123rrr, as amended by this act.

665 [(a)] (b) Not later than September first, annually, the Secretary of the
666 Office of Policy and Management, in consultation with the
667 Commissioner of Public Health, shall:

668 (1) [determine] Determine the amounts appropriated for the syringe
669 services program, AIDS services, breast and cervical cancer detection
670 and treatment, x-ray screening and tuberculosis care, sexually
671 transmitted disease control and children's health initiatives; and

672 (2) [inform] Inform the Insurance Commissioner of such amounts.

673 [(b) (1) As used in this section: (A) "Health insurance" means health
674 insurance of the types specified in subdivisions (1), (2), (4), (11) and (12)
675 of section 38a-469; and (B) "health care center" has the same meaning as
676 provided in section 38a-175.]

677 [(2)] (c) (1) Each domestic insurer [or] and domestic health care center
678 doing health insurance business in this state, and the Comptroller on
679 behalf of each multiemployer plan, nonprofit employer and small
680 employer receiving coverage provided by the Comptroller pursuant to
681 section 2 of this act, shall annually pay to the Insurance Commissioner,
682 for deposit in the Insurance Fund established under section 38a-52a, a
683 public health fee assessed by the Insurance Commissioner pursuant to
684 this section.

685 [(3)] (2) Not later than September first, annually: [, each such]

686 (A) Each domestic insurer [or] and domestic health care center
687 described in subdivision (1) of this subsection shall report to the
688 Insurance Commissioner, in the form and manner prescribed by [said
689 commissioner] the Insurance Commissioner, the number of insured or
690 enrolled lives in this state as of the May first immediately preceding [the
691 date] for which such domestic insurer or domestic health care center [is]
692 was providing health insurance [that provides] coverage, [of the types
693 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469.
694 Such number shall not include] excluding any lives enrolled in
695 Medicare, any medical assistance program administered by the

696 Department of Social Services, workers' compensation insurance or
697 Medicare Part C plans; and

698 (B) The Comptroller shall report to the Insurance Commissioner, in
699 the form and manner prescribed by the Insurance Commissioner:

700 (i) For each multiemployer plan described in subdivision (1) of this
701 subsection, the number of such multiemployer plan's plan participants
702 and beneficiaries in this state for whom the Comptroller was providing
703 coverage pursuant to section 2 of this act as of the May first immediately
704 preceding;

705 (ii) For each nonprofit employer described in subdivision (1) of this
706 subsection, the number of such nonprofit employer's employees and
707 their dependents in this state for whom the Comptroller was providing
708 coverage pursuant to section 2 of this act as of the May first immediately
709 preceding; and

710 (iii) For each small employer described in subdivision (1) of this
711 subsection, the number of such small employer's employees and their
712 dependents in this state for whom the Comptroller was providing
713 coverage pursuant to section 2 of this act as of the May first immediately
714 preceding.

715 ~~[(c)]~~ (d) Not later than November first, annually, the Insurance
716 Commissioner shall determine the fee to be assessed for the current
717 fiscal year against each [such] domestic insurer, [and] domestic health
718 care center, multiemployer plan, nonprofit employer or small employer
719 described in subdivision (1) of subsection (c) of this section. Such fee
720 shall be calculated by multiplying the number of lives reported to [said
721 commissioner] the Insurance Commissioner pursuant to subparagraph
722 (A) of subdivision [(3)] (2) of subsection [(b)] (c) of this section, and the
723 number of plan participants, beneficiaries, employees and dependents
724 reported to the Insurance Commissioner pursuant to subparagraph (B)
725 of subdivision (2) of subsection (c) of this section, by a factor,
726 determined annually by [said commissioner] the Insurance
727 Commissioner as set forth in this subsection, to fully fund the aggregate

728 amount determined under subdivision (1) of subsection [(a)] (b) of this
729 section. The Insurance Commissioner shall determine the factor by
730 dividing the aggregate amount by the sum of the total number of lives
731 reported to [said commissioner] the Insurance Commissioner pursuant
732 to subparagraph (A) of subdivision [(3)] (2) of subsection [(b)] (c) of this
733 section and the number of plan participants, beneficiaries, employees
734 and dependents reported to the Insurance Commissioner pursuant to
735 subparagraph (B) of subdivision (2) of subsection (c) of this section.

736 [(d)] (e) Not later than December first, annually, the Insurance
737 Commissioner shall submit a statement to each [such] domestic insurer
738 and domestic health care center described in subdivision (1) of
739 subsection (c) of this section, and to the Comptroller for each
740 multiemployer plan, nonprofit employer or small employer described
741 in subdivision (1) of subsection (c) of this section, that includes the
742 proposed fee, identified on such statement as the "Public Health fee", for
743 [the] such domestic insurer, [or] domestic health care center,
744 multiemployer plan, nonprofit employer or small employer, calculated
745 in accordance with this section. Not later than December twentieth,
746 annually, [any] a domestic insurer, [or] domestic health care center, or
747 the Comptroller acting on behalf of a multiemployer plan, nonprofit
748 employer or small employer, may submit an objection to the Insurance
749 Commissioner concerning the proposed public health fee. The
750 Insurance Commissioner, after making any adjustment that [said
751 commissioner] the Insurance Commissioner deems necessary, shall, not
752 later than January first, annually, submit a final statement to the
753 Comptroller for each multiemployer plan, nonprofit employer and
754 small employer described in subdivision (1) of subsection (c) of this
755 section that includes the final fee for such multiemployer plan, nonprofit
756 employer or small employer and to each domestic insurer and domestic
757 health care center that includes the final fee for [the] such domestic
758 insurer or domestic health care center. [Each such] The Comptroller
759 shall collect such fee from each such multiemployer plan, nonprofit
760 employer and small employer and pay such fee to the Insurance
761 Commissioner, and each such domestic insurer and domestic health

762 care center shall pay such fee to the Insurance Commissioner, not later
763 than February first, annually.

764 [(e)] (f) Any [such] domestic insurer, [or] domestic health care center,
765 multiemployer plan, nonprofit employer or small employer described
766 in subdivision (1) of subsection (c) of this section that is aggrieved by an
767 assessment levied under this section may appeal therefrom in the same
768 manner as provided for appeals under section 38a-52, as amended by
769 this act.

770 [(f)] (g) (1) The Insurance Commissioner shall apply an overpayment
771 of the public health fee by [an] a domestic insurer or domestic health
772 care center, or by the Comptroller on behalf of a multiemployer plan,
773 nonprofit employer or small employer described in subdivision (1) of
774 subsection (c) of this section, for any fiscal year as a credit against the
775 public health fee due from such domestic insurer, [or] domestic health
776 care center, multiemployer plan, nonprofit employer or small employer
777 for the succeeding fiscal year, subject to an adjustment under subsection
778 [(c)] (d) of this section; [if:]

779 (A) [The] If the amount of the overpayment exceeds five thousand
780 dollars; and

781 (B) If, on or before June first of the calendar year of the overpayment,
782 [the] such domestic insurer, [or] domestic health care center,
783 multiemployer plan, nonprofit employer or small employer:

784 (i) [notifies] Notifies the [commissioner] Insurance Commissioner of
785 the amount of the overpayment; [and

786 (ii) [provides] Provides the [commissioner] Insurance Commissioner
787 with evidence sufficient to prove the amount of the overpayment.

788 (2) Not later than ninety days following receipt of notice and
789 supporting evidence under subdivision (1) of this subsection, the
790 [commissioner] Insurance Commissioner shall:

791 (A) [determine] Determine whether the domestic insurer, [or]

792 domestic health care center, multiemployer plan, nonprofit employer or
793 small employer made an overpayment; [,] and

794 (B) [notify] Notify the domestic insurer, [or] domestic health care
795 center, multiemployer plan, nonprofit employer or small employer of
796 such determination.

797 (3) Failure of [an] a domestic insurer, [or] domestic health care center,
798 multiemployer plan, nonprofit employer or small employer to notify the
799 commissioner of the amount of an overpayment within the time
800 prescribed in subdivision (1) of this subsection constitutes a waiver of
801 any demand of the domestic insurer, [or] domestic health care center,
802 multiemployer plan, nonprofit employer or small employer against the
803 state on account of such overpayment.

804 (4) Nothing in this subsection shall be construed to prohibit or limit
805 the right of [an] a domestic insurer, [or] domestic health care center,
806 multiemployer plan, nonprofit employer or small employer to appeal
807 pursuant to subsection [(e)] (f) of this section.

808 Sec. 7. Section 38a-52 of the general statutes is repealed and the
809 following is substituted in lieu thereof (*Effective July 1, 2021*):

810 Any (1) domestic insurance company or other domestic entity
811 aggrieved because of any assessment levied under section 38a-48, (2)
812 fraternal benefit society or foreign or alien insurance company or other
813 entity aggrieved because of any assessment levied under the provisions
814 of sections 38a-49 to 38a-51, inclusive, [or] (3) domestic insurer, domestic
815 health care center, third-party administrator licensed pursuant to
816 section 38a-720a or exempt insurer, administrator of a multiemployer
817 plan, nonprofit employer or small employer, as defined in [subdivision
818 (1) of] subsection [(b)] (a) of section 19a-7j, as amended by this act,
819 aggrieved because of any assessment levied under said section 19a-7j,
820 or (4) domestic insurer, domestic health care center, administrator of a
821 multiemployer plan, nonprofit employer or small employer, as defined
822 in subsection (a) of section 19a-7p, aggrieved because of any assessment
823 levied under said section 19a-7p, may, within one month from the time

824 provided for the payment of such assessment, appeal therefrom to the
825 superior court for the judicial district of New Britain, which appeal shall
826 be accompanied by a citation to the commissioner to appear before said
827 court. Such citation shall be signed by the same authority, and such
828 appeal shall be returnable at the same time and served and returned in
829 the same manner, as is required in case of a summons in a civil action.
830 The authority issuing the citation shall take from the appellant a bond
831 or recognizance to the state, with surety to prosecute the appeal to effect
832 and to comply with the orders and decrees of the court in the premises.
833 Such appeals shall be preferred cases, to be heard, unless cause appears
834 to the contrary, at the first session, by the court or by a committee
835 appointed by the court. Said court may grant such relief as may be
836 equitable, and, if such assessment has been paid prior to the granting of
837 such relief, may order the Treasurer to pay the amount of such relief,
838 with interest at the rate of six per cent per annum, to the aggrieved
839 company. If the appeal has been taken without probable cause, the court
840 may tax double or triple costs, as the case demands; and, upon all such
841 appeals which may be denied, costs may be taxed against the appellant
842 at the discretion of the court, but no costs shall be taxed against the state.

843 Sec. 8. Section 38a-1041 of the general statutes is repealed and the
844 following is substituted in lieu thereof (*Effective July 1, 2021*):

845 (a) There is established an Office of the Healthcare Advocate which
846 shall be within the Insurance Department for administrative purposes
847 only.

848 (b) The Office of the Healthcare Advocate may:

849 (1) Assist health insurance consumers with managed care plan
850 selection by providing information, referral and assistance to
851 individuals about means of obtaining health insurance coverage and
852 services;

853 (2) Assist health insurance consumers to understand their rights and
854 responsibilities under managed care plans;

855 (3) Provide information to the public, agencies, legislators and others
856 regarding problems and concerns of health insurance consumers and
857 make recommendations for resolving those problems and concerns;

858 (4) Assist consumers with the filing of complaints and appeals,
859 including filing appeals with a managed care organization's internal
860 appeal or grievance process and the external appeal process established
861 under sections 38a-591d to 38a-591g, inclusive;

862 (5) Analyze and monitor the development and implementation of
863 federal, state and local laws, regulations and policies relating to health
864 insurance consumers and recommend changes it deems necessary;

865 (6) Facilitate public comment on laws, regulations and policies,
866 including policies and actions of health insurers;

867 (7) Ensure that health insurance consumers have timely access to the
868 services provided by the office;

869 (8) Review the health insurance records of a consumer who has
870 provided written consent for such review;

871 (9) Create and make available to employers a notice, suitable for
872 posting in the workplace, concerning the services that the Healthcare
873 Advocate provides;

874 (10) Establish a toll-free number, or any other free calling option, to
875 allow customer access to the services provided by the Healthcare
876 Advocate;

877 (11) Pursue administrative remedies on behalf of and with the
878 consent of any health insurance consumers;

879 (12) Adopt regulations, pursuant to chapter 54, to carry out the
880 provisions of sections 38a-1040 to 38a-1050, inclusive; and

881 (13) Take any other actions necessary to fulfill the purposes of
882 sections 38a-1040 to 38a-1050, inclusive.

883 (c) The Office of the Healthcare Advocate shall make a referral to the
884 Insurance Commissioner if the Healthcare Advocate finds that a
885 preferred provider network may have engaged in a pattern or practice
886 that may be in violation of sections 38a-479aa to 38a-479gg, inclusive, or
887 38a-815 to 38a-819, inclusive.

888 (d) The Healthcare Advocate and the Insurance Commissioner shall
889 jointly compile a list of complaints received against managed care
890 organizations and preferred provider networks and the commissioner
891 shall maintain the list, except the names of complainants shall not be
892 disclosed if such disclosure would violate the provisions of section 4-
893 61dd or 38a-1045.

894 (e) On or before October 1, 2005, the Managed Care Ombudsman
895 shall establish a process to provide ongoing communication among
896 mental health care providers, patients, state-wide and regional business
897 organizations, managed care companies and other health insurers to
898 assure: (1) Best practices in mental health treatment and recovery; (2)
899 compliance with the provisions of sections 38a-476a, 38a-476b, 38a-488a
900 and 38a-489; and (3) the relative costs and benefits of providing effective
901 mental health care coverage to employees and their families. On or
902 before January 1, 2006, and annually thereafter, the Healthcare
903 Advocate shall report, in accordance with the provisions of section 11-
904 4a, on the implementation of this subsection to the joint standing
905 committees of the General Assembly having cognizance of matters
906 relating to public health and insurance.

907 (f) On or before October 1, 2008, the Office of the Healthcare Advocate
908 shall, within available appropriations, establish and maintain a
909 healthcare consumer information web site on the Internet for use by the
910 public in obtaining healthcare information, including but not limited to:
911 (1) The availability of wellness programs in various regions of
912 Connecticut, such as disease prevention and health promotion
913 programs; (2) quality and experience data from hospitals licensed in this
914 state; and (3) a link to the consumer report card developed and
915 distributed by the Insurance Commissioner pursuant to section 38a-

916 478l.

917 (g) Not later than January 1, 2015, the Office of the Healthcare
918 Advocate shall establish an information and referral service to help
919 residents and providers receive behavioral health care information,
920 timely referrals and access to behavioral health care providers. In
921 developing and implementing such service, the Healthcare Advocate,
922 or the Healthcare Advocate's designee, shall: (1) Collaborate with
923 stakeholders, including, but not limited to, (A) state agencies, (B) the
924 Behavioral Health Partnership established pursuant to section 17a-22h,
925 (C) community collaboratives, (D) the United Way's 2-1-1 Infoline
926 program, and (E) providers; (2) identify any basis that prevents
927 residents from obtaining adequate and timely behavioral health care
928 services, including, but not limited to, (A) gaps in private behavioral
929 health care services and coverage, and (B) barriers to access to care; (3)
930 coordinate a public awareness and educational campaign directing
931 residents to the information and referral service; and (4) develop data
932 reporting mechanisms to determine the effectiveness of the service,
933 including, but not limited to, tracking (A) the number of referrals to
934 providers by type and location of providers, (B) waiting time for
935 services, and (C) the number of providers who accept or reject requests
936 for service based on type of health care coverage. Not later than
937 February 1, 2016, and annually thereafter, the Office of the Healthcare
938 Advocate shall submit a report, in accordance with the provisions of
939 section 11-4a, to the joint standing committees of the General Assembly
940 having cognizance of matters relating to children, human services,
941 public health and insurance. The report shall identify gaps in services
942 and the resources needed to improve behavioral health care options for
943 residents.

944 (h) The Office of the Healthcare Advocate shall provide assistance to
945 the plan participants and beneficiaries in this state under multiemployer
946 plans, nonprofit employers' employees and their dependents and small
947 employers' employees and their dependents receiving coverage
948 provided by the Comptroller pursuant to section 2 of this act that is
949 equivalent to the assistance that the Office of the Healthcare Advocate

950 provides to health insurance consumers.

951 Sec. 9. (NEW) (*Effective July 1, 2021*) (a) For the purposes of this
952 section:

953 (1) "Connecticut Health Insurance Exchange account" means the
954 Connecticut Health Insurance Exchange account established under
955 section 13 of this act;

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

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

962 (4) "Office of Health Strategy" means the Office of Health Strategy
963 established under section 19a-754a of the general statutes, as amended
964 by this act.

965 (b) (1) Subject to the approval required under subsection (d) of section
966 16 of this act and, with respect to the matters for which the exchange
967 seeks a state innovation waiver pursuant to subparagraph (B) of
968 subdivision (28) of section 38a-1084 of the general statutes, as amended
969 by this act, issuance of such state innovation waiver, the Office of Health
970 Strategy shall:

971 (A) Not later than July 1, 2022, and annually thereafter:

972 (i) Determine the amount that the exchange requires to perform its
973 duties under subparagraph (C) of subdivision (28) of section 38a-1084 of
974 the general statutes, as amended by this act; and

975 (ii) Report the amount determined pursuant to subparagraph (A)(i)
976 of this subdivision to the Insurance Commissioner; and

977 (B) Not later than July 1, 2021, report to the Insurance Commissioner

978 that the amount described in subparagraph (A)(i) of this subdivision is
979 fifty million dollars for the year 2022.

980 (2) The amount determined pursuant to subparagraph (A)(i) of
981 subdivision (1) of this subsection shall not exceed fifty million dollars
982 for any year.

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

988 (2) Not later than July 1, 2021, and annually thereafter, each insurer,
989 health care center and exempt insurer described in subdivision (1) of
990 this subsection shall report to the commissioner, on a form designated
991 by the commissioner, the number of insured or enrolled lives in this
992 state as of the May first immediately preceding for which such insurer,
993 health care center or exempt insurer was providing health insurance
994 coverage, or administering a self-insured health benefit plan providing
995 coverage, of the types specified in subdivisions (1), (2), (4), (11) and (12)
996 of section 38a-469 of the general statutes. Such number shall not include
997 insured or enrolled lives covered under fully insured group health
998 insurance policies sold in the small group market, Medicare, any
999 medical assistance program administered by the Department of Social
1000 Services, workers' compensation insurance or Medicare Part C plans.

1001 (3) Not later than August 1, 2021, and annually thereafter, the
1002 commissioner shall determine the fee to be assessed for that year against
1003 each insurer, health care center and exempt insurer described in
1004 subdivision (1) of this subsection. Such fee shall be determined by
1005 multiplying the number of insured or enrolled lives reported to the
1006 commissioner pursuant to subdivision (2) of this subsection by a factor,
1007 determined annually by the commissioner, to fully fund the amount
1008 reported by the Office of Health Strategy to the commissioner pursuant
1009 to subparagraph (A)(ii) or (B) of subdivision (1) of subsection (b) of this

1010 section. The commissioner shall determine the factor by dividing the
1011 amount reported by the Office of Health Strategy to the commissioner
1012 pursuant to subparagraph (A)(ii) or (B) of subdivision (1) of subsection
1013 (b) of this section by the total number of insured or enrolled lives
1014 reported to the commissioner pursuant to subdivision (2) of this
1015 subsection.

1016 (4) (A) Not later than August 1, 2021, and annually thereafter, the
1017 commissioner shall submit a statement to each insurer, health care
1018 center and exempt insurer described in subdivision (1) of this subsection
1019 that includes the proposed fee imposed under this section for such
1020 insurer, health care center or exempt insurer determined in accordance
1021 with this subsection. Each such insurer, health care center and exempt
1022 insurer shall pay such fee to the commissioner not later than November
1023 first of that year.

1024 (B) Any insurer, health care center or exempt insurer described in
1025 subdivision (1) of this subsection that is aggrieved by an assessment
1026 levied under this subsection may appeal therefrom in the same manner
1027 as provided for appeals under section 38a-52 of the general statutes, as
1028 amended by this act.

1029 (5) Any insurer, health care center or exempt insurer that fails to file
1030 the report required under subdivision (2) of this subsection, or pay the
1031 fee assessed under subdivision (1) of this subsection, shall pay a late
1032 filing or payment fee, as applicable, of one hundred dollars per day for
1033 each day from the date such report or payment was due. The
1034 commissioner shall deposit all late fees paid pursuant to this
1035 subdivision in the Connecticut Health Insurance Exchange account. The
1036 commissioner may require an insurer, health care center or exempt
1037 insurer subject to this subsection to produce any records in its
1038 possession, and may require any other person to produce any records
1039 in such other person's possession, that were used to prepare such report
1040 for examination by the commissioner or the commissioner's designee. If
1041 the commissioner determines there exists anything other than a good
1042 faith discrepancy between the actual number of insured or enrolled lives

1043 that should have been reported to the commissioner pursuant to
1044 subdivision (2) of this subsection and the number actually reported,
1045 such insurer, health care center or exempt insurer shall be liable to this
1046 state for a civil penalty of not more than fifteen thousand dollars for each
1047 report filed for which the commissioner determines there is such a
1048 discrepancy.

1049 (6) (A) The commissioner shall apply any overpayment of the fee
1050 imposed under this section by an insurer, health care center or exempt
1051 insurer for a given year as a credit against the fee due from such insurer,
1052 health care center or exempt insurer under this section for the
1053 succeeding year if:

1054 (i) The amount of the overpayment exceeds five thousand dollars;
1055 and

1056 (ii) On or before April first of the year of the overpayment, the
1057 insurer, health care center or exempt insurer:

1058 (I) Notifies the commissioner of the amount of the overpayment; and

1059 (II) Provides the commissioner with evidence sufficient to prove the
1060 amount of the overpayment.

1061 (B) Not later than ninety days after the commissioner receives the
1062 notice and supporting evidence under subparagraph (A)(ii) of this
1063 subdivision, the commissioner shall:

1064 (i) Determine whether the insurer, health care center or exempt
1065 insurer made an overpayment; and

1066 (ii) Notify the insurer, health care center or exempt insurer of the
1067 commissioner's determination under subparagraph (B)(i) of this
1068 subdivision.

1069 (C) Failure of an insurer, health care center or exempt insurer to
1070 notify the commissioner of the amount of an overpayment within the
1071 time prescribed in subparagraph (A)(ii) of this subdivision constitutes a

1072 waiver of any demand of the insurer, health care center or exempt
1073 insurer against this state on account of such overpayment.

1074 (D) Nothing in this subdivision shall be construed to prohibit or limit
1075 the right of an insurer, health care center or exempt insurer to appeal
1076 pursuant to subparagraph (B) of subdivision (4) of this subsection.

1077 (d) If another state, territory or district of the United States, or a
1078 foreign country, imposes on a Connecticut domiciled insurer, fraternal
1079 benefit society, hospital service corporation, medical service
1080 corporation, health care center or other domestic entity a retaliatory
1081 charge for the fee imposed under this section, such domestic entity may,
1082 not later than sixty days after receipt of notice of the imposition of the
1083 retaliatory charge for such fee, appeal to the Insurance Commissioner
1084 for a verification that the fee imposed under this section is subject to
1085 retaliation by another state, territory or district of the United States, or a
1086 foreign country. If the commissioner verifies, upon appeal to and
1087 certification by the commissioner, that the fee imposed under this
1088 section is the subject of a retaliatory tax, fee, assessment or other
1089 obligation by another state, territory or district of the United States, or a
1090 foreign country, such fee shall not be assessed against nondomestic
1091 insurers and nondomestic exempt insurers pursuant to this section. Any
1092 such domestic insurer, fraternal benefit society, hospital service
1093 corporation, medical service corporation, health care center or other
1094 entity aggrieved by the commissioner's decision issued under this
1095 subsection may appeal therefrom in the same manner as provided
1096 under section 38a-52 of the general statutes.

1097 (e) The Insurance Commissioner may adopt regulations, in
1098 accordance with chapter 54 of the general statutes, to implement the
1099 provisions of this section.

1100 Sec. 10. Section 38a-1080 of the general statutes is repealed and the
1101 following is substituted in lieu thereof (*Effective July 1, 2021*):

1102 For purposes of sections 38a-1080 to 38a-1093, inclusive, as amended
1103 by this act, and sections 13 and 14 of this act:

1104 (1) "Affordable Care Act" means the Patient Protection and
1105 Affordable Care Act, P.L. 111-148, as amended by the Health Care and
1106 Education Reconciliation Act, P.L. 111-152, as both may be amended
1107 from time to time, and regulations adopted thereunder;

1108 [(1)] (2) "Board" means the board of directors of the Connecticut
1109 Health Insurance Exchange;

1110 [(2)] (3) "Commissioner" means the Insurance Commissioner;

1111 [(3)] (4) "Exchange" means the Connecticut Health Insurance
1112 Exchange established pursuant to section 38a-1081;

1113 [(4) "Affordable Care Act" means the Patient Protection and
1114 Affordable Care Act, P.L. 111-148, as amended by the Health Care and
1115 Education Reconciliation Act, P.L. 111-152, as both may be amended
1116 from time to time, and regulations adopted thereunder;]

1117 (5) (A) "Health benefit plan" means an insurance policy or contract
1118 offered, delivered, issued for delivery, renewed, amended or continued
1119 in the state by a health carrier to provide, deliver, pay for or reimburse
1120 any of the costs of health care services.

1121 (B) "Health benefit plan" does not include:

1122 (i) Coverage of the type specified in subdivisions (5), (6), (7), (8), (9),
1123 (14), (15) and (16) of section 38a-469 or any combination thereof;

1124 (ii) Coverage issued as a supplement to liability insurance;

1125 (iii) Liability insurance, including general liability insurance and
1126 automobile liability insurance;

1127 (iv) Workers' compensation insurance;

1128 (v) Automobile medical payment insurance;

1129 (vi) Credit insurance;

1130 (vii) Coverage for on-site medical clinics; or

1131 (viii) Other similar insurance coverage specified in regulations issued
1132 pursuant to the Health Insurance Portability and Accountability Act of
1133 1996, P.L. 104-191, as amended from time to time, under which benefits
1134 for health care services are secondary or incidental to other insurance
1135 benefits.

1136 (C) "Health benefit plan" does not include the following benefits if
1137 they are provided under a separate insurance policy, certificate or
1138 contract or are otherwise not an integral part of the plan:

1139 (i) Limited scope dental or vision benefits;

1140 (ii) Benefits for long-term care, nursing home care, home health care,
1141 community-based care or any combination thereof; or

1142 (iii) Other similar, limited benefits specified in regulations issued
1143 pursuant to the Health Insurance Portability and Accountability Act of
1144 1996, P.L. 104-191, as amended from time to time;

1145 (iv) Other supplemental coverage, similar to coverage of the type
1146 specified in subdivisions (9) and (14) of section 38a-469, provided under
1147 a group health plan.

1148 (D) "Health benefit plan" does not include coverage of the type
1149 specified in subdivisions (3) and (13) of section 38a-469 or other fixed
1150 indemnity insurance if (i) such coverage is provided under a separate
1151 insurance policy, certificate or contract, (ii) there is no coordination
1152 between the provision of the benefits and any exclusion of benefits
1153 under any group health plan maintained by the same plan sponsor, and
1154 (iii) the benefits are paid with respect to an event without regard to
1155 whether benefits were also provided under any group health plan
1156 maintained by the same plan sponsor;

1157 (6) "Health care services" has the same meaning as provided in
1158 section 38a-478;

1159 (7) "Health carrier" means an insurance company, fraternal benefit
1160 society, hospital service corporation, medical service corporation, health
1161 care center or other entity subject to the insurance laws and regulations
1162 of the state or the jurisdiction of the commissioner that contracts or
1163 offers to contract to provide, deliver, pay for or reimburse any of the
1164 costs of health care services;

1165 (8) "Internal Revenue Code" means the Internal Revenue Code of
1166 1986, or any subsequent corresponding internal revenue code of the
1167 United States, as amended from time to time;

1168 [(9) "Person" has the same meaning as provided in section 38a-1;

1169 (10)] (9) "Qualified dental plan" means a limited scope dental plan
1170 that has been certified in accordance with subsection (e) of section 38a-
1171 1086;

1172 [(11)] (10) "Qualified employer" has the same meaning as provided in
1173 Section 1312 of the Affordable Care Act;

1174 [(12)] (11) "Qualified health plan" means a health benefit plan that has
1175 in effect a certification that the plan meets the criteria for certification
1176 described in Section 1311(c) of the Affordable Care Act and section 38a-
1177 1086;

1178 [(13)] (12) "Qualified individual" has the same meaning as provided
1179 in Section 1312 of the Affordable Care Act;

1180 [(14)] (13) "Secretary" means the Secretary of the United States
1181 Department of Health and Human Services; and

1182 [(15)] (14) "Small employer" has the same meaning as provided in
1183 section 38a-564.

1184 Sec. 11. Section 38a-1084 of the general statutes is repealed and the
1185 following is substituted in lieu thereof (*Effective July 1, 2021*):

1186 The exchange shall:

1187 (1) Administer the exchange for both qualified individuals and
1188 qualified employers;

1189 (2) Commission surveys of individuals, small employers and health
1190 care providers on issues related to health care and health care coverage;

1191 (3) Implement procedures for the certification, recertification and
1192 decertification, consistent with guidelines developed by the Secretary
1193 under Section 1311(c) of the Affordable Care Act, and section 38a-1086,
1194 of health benefit plans as qualified health plans;

1195 (4) Provide for the operation of a toll-free telephone hotline to
1196 respond to requests for assistance;

1197 (5) Provide for enrollment periods, as provided under Section
1198 1311(c)(6) of the Affordable Care Act;

1199 (6) Maintain an Internet web site through which enrollees and
1200 prospective enrollees of qualified health plans may obtain standardized
1201 comparative information on such plans including, but not limited to, the
1202 enrollee satisfaction survey information under Section 1311(c)(4) of the
1203 Affordable Care Act and any other information or tools to assist
1204 enrollees and prospective enrollees evaluate qualified health plans
1205 offered through the exchange;

1206 (7) Publish the average costs of licensing, regulatory fees and any
1207 other payments required by the exchange and the administrative costs
1208 of the exchange, including information on moneys lost to waste, fraud
1209 and abuse, on an Internet web site to educate individuals on such costs;

1210 (8) On or before the open enrollment period for plan year 2017, assign
1211 a rating to each qualified health plan offered through the exchange in
1212 accordance with the criteria developed by the Secretary under Section
1213 1311(c)(3) of the Affordable Care Act, and determine each qualified
1214 health plan's level of coverage in accordance with regulations issued by
1215 the Secretary under Section 1302(d)(2)(A) of the Affordable Care Act;

1216 (9) Use a standardized format for presenting health benefit options in

1217 the exchange, including the use of the uniform outline of coverage
1218 established under Section 2715 of the Public Health Service Act, 42 USC
1219 300gg-15, as amended from time to time;

1220 (10) Inform individuals, in accordance with Section 1413 of the
1221 Affordable Care Act, of eligibility requirements for the Medicaid
1222 program under Title XIX of the Social Security Act, as amended from
1223 time to time, the Children's Health Insurance Program (CHIP) under
1224 Title XXI of the Social Security Act, as amended from time to time, or
1225 any applicable state or local public program, and enroll an individual in
1226 such program if the exchange determines, through screening of the
1227 application by the exchange, that such individual is eligible for any such
1228 program;

1229 (11) Collaborate with the Department of Social Services, to the extent
1230 possible, to allow an enrollee who loses premium tax credit eligibility
1231 under Section 36B of the Internal Revenue Code and is eligible for
1232 HUSKY A or any other state or local public program, to remain enrolled
1233 in a qualified health plan;

1234 (12) Establish and make available by electronic means a calculator to
1235 determine the actual cost of coverage after application of any premium
1236 tax credit under Section 36B of the Internal Revenue Code and any cost-
1237 sharing reduction under Section 1402 of the Affordable Care Act;

1238 (13) Establish a program for small employers through which
1239 qualified employers may access coverage for their employees and that
1240 shall enable any qualified employer to specify a level of coverage so that
1241 any of its employees may enroll in any qualified health plan offered
1242 through the exchange at the specified level of coverage;

1243 (14) Offer enrollees and small employers the option of having the
1244 exchange collect and administer premiums, including through
1245 allocation of premiums among the various insurers and qualified health
1246 plans chosen by individual employers;

1247 (15) Grant a certification, subject to Section 1411 of the Affordable

1248 Care Act, attesting that, for purposes of the individual responsibility
1249 penalty under Section 5000A of the Internal Revenue Code, an
1250 individual is exempt from the individual responsibility requirement or
1251 from the penalty imposed by said Section 5000A because:

1252 (A) There is no affordable qualified health plan available through the
1253 exchange, or the individual's employer, covering the individual; or

1254 (B) The individual meets the requirements for any other such
1255 exemption from the individual responsibility requirement or penalty;

1256 (16) Provide to the Secretary of the Treasury of the United States the
1257 following:

1258 (A) A list of the individuals granted a certification under subdivision
1259 (15) of this section, including the name and taxpayer identification
1260 number of each individual;

1261 (B) The name and taxpayer identification number of each individual
1262 who was an employee of an employer but who was determined to be
1263 eligible for the premium tax credit under Section 36B of the Internal
1264 Revenue Code because:

1265 (i) The employer did not provide minimum essential health benefits
1266 coverage; or

1267 (ii) The employer provided the minimum essential coverage but it
1268 was determined under Section 36B(c)(2)(C) of the Internal Revenue
1269 Code to be unaffordable to the employee or not provide the required
1270 minimum actuarial value; and

1271 (C) The name and taxpayer identification number of:

1272 (i) Each individual who notifies the exchange under Section
1273 1411(b)(4) of the Affordable Care Act that such individual has changed
1274 employers; and

1275 (ii) Each individual who ceases coverage under a qualified health

1276 plan during a plan year and the effective date of that cessation;

1277 (17) Provide to each employer the name of each employee, as
1278 described in subparagraph (B) of subdivision (16) of this section, of the
1279 employer who ceases coverage under a qualified health plan during a
1280 plan year and the effective date of the cessation;

1281 (18) Perform duties required of, or delegated to, the exchange by the
1282 Secretary or the Secretary of the Treasury of the United States related to
1283 determining eligibility for premium tax credits, reduced cost-sharing or
1284 individual responsibility requirement exemptions;

1285 (19) Select entities qualified to serve as Navigators in accordance with
1286 Section 1311(i) of the Affordable Care Act and award grants to enable
1287 Navigators to:

1288 (A) Conduct public education activities to raise awareness of the
1289 availability of qualified health plans;

1290 (B) Distribute fair and impartial information concerning enrollment
1291 in qualified health plans and the availability of premium tax credits
1292 under Section 36B of the Internal Revenue Code and cost-sharing
1293 reductions under Section 1402 of the Affordable Care Act;

1294 (C) Facilitate enrollment in qualified health plans;

1295 (D) Provide referrals to the Office of the Healthcare Advocate or
1296 health insurance ombudsman established under Section 2793 of the
1297 Public Health Service Act, 42 USC 300gg-93, as amended from time to
1298 time, or any other appropriate state agency or agencies, for any enrollee
1299 with a grievance, complaint or question regarding the enrollee's health
1300 benefit plan, coverage or a determination under that plan or coverage;
1301 and

1302 (E) Provide information in a manner that is culturally and
1303 linguistically appropriate to the needs of the population being served by
1304 the exchange;

1305 (20) Review the rate of premium growth within and outside the
1306 exchange and consider such information in developing
1307 recommendations on whether to continue limiting qualified employer
1308 status to small employers;

1309 (21) Credit the amount, in accordance with Section 10108 of the
1310 Affordable Care Act, of any free choice voucher to the monthly
1311 premium of the plan in which a qualified employee is enrolled and
1312 collect the amount credited from the offering employer;

1313 (22) Consult with stakeholders relevant to carrying out the activities
1314 required under sections 38a-1080 to 38a-1090, inclusive, as amended by
1315 this act, including, but not limited to:

1316 (A) Individuals who are knowledgeable about the health care system,
1317 have background or experience in making informed decisions regarding
1318 health, medical and scientific matters and are enrollees in qualified
1319 health plans;

1320 (B) Individuals and entities with experience in facilitating enrollment
1321 in qualified health plans;

1322 (C) Representatives of small employers and self-employed
1323 individuals;

1324 (D) The Department of Social Services; and

1325 (E) Advocates for enrolling hard-to-reach populations;

1326 (23) Meet the following financial integrity requirements:

1327 (A) Keep an accurate accounting of all activities, receipts and
1328 expenditures and annually submit to the Secretary, the Governor, the
1329 Insurance Commissioner and the General Assembly a report concerning
1330 such accountings;

1331 (B) Fully cooperate with any investigation conducted by the Secretary
1332 pursuant to the Secretary's authority under the Affordable Care Act and

1333 allow the Secretary, in coordination with the Inspector General of the
1334 United States Department of Health and Human Services, to:

1335 (i) Investigate the affairs of the exchange;

1336 (ii) Examine the properties and records of the exchange; and

1337 (iii) Require periodic reports in relation to the activities undertaken
1338 by the exchange; and

1339 (C) Not use any funds in carrying out its activities under sections 38a-
1340 1080 to 38a-1089, inclusive, as amended by this act, that are intended for
1341 the administrative and operational expenses of the exchange, for staff
1342 retreats, promotional giveaways, excessive executive compensation or
1343 promotion of federal or state legislative and regulatory modifications;

1344 (24) (A) Seek to include the most comprehensive health benefit plans
1345 that offer high quality benefits at the most affordable price in the
1346 exchange, (B) encourage health carriers to offer tiered health care
1347 provider network plans that have different cost-sharing rates for
1348 different health care provider tiers and reward enrollees for choosing
1349 low-cost, high-quality health care providers by offering lower
1350 copayments, deductibles or other out-of-pocket expenses, and (C) offer
1351 any such tiered health care provider network plans through the
1352 exchange; [and]

1353 (25) Report at least annually to the General Assembly on the effect of
1354 adverse selection on the operations of the exchange and make legislative
1355 recommendations, if necessary, to reduce the negative impact from any
1356 such adverse selection on the sustainability of the exchange, including
1357 recommendations to ensure that regulation of insurers and health
1358 benefit plans are similar for qualified health plans offered through the
1359 exchange and health benefit plans offered outside the exchange. The
1360 exchange shall evaluate whether adverse selection is occurring with
1361 respect to health benefit plans that are grandfathered under the
1362 Affordable Care Act, self-insured plans, plans sold through the
1363 exchange and plans sold outside the exchange; [.]

1364 (26) Administer the Connecticut Health Insurance Exchange account
1365 established under section 13 of this act;

1366 (27) Consult with the Office of Health Strategy established under
1367 section 19a-754a, as amended by this act, for the purposes set forth in
1368 subsection (b) of section 16 of this act;

1369 (28) Subject to the approval required under subsection (d) of section
1370 16 of this act:

1371 (A) Establish the subsidiary described in subdivision (1) of subsection
1372 (b) of section 16 of this act not later than November 1, 2021, which, if
1373 established, shall:

1374 (i) Require each health carrier offering coverage through such
1375 subsidiary to:

1376 (I) Collect demographic data, including, but not limited to, self-
1377 reported ethnic and racial data, concerning the individuals receiving
1378 such coverage by, at a minimum, utilizing standardized categories
1379 developed by the Office of Health Strategy pursuant to subdivision (9)
1380 of subsection (b) of section 19a-754a of the general statutes, as amended
1381 by this act, including an "other" category and allowing any individual
1382 who is self-reporting ethnic or racial data to write in such individual's
1383 ethnicity or race, and select multiple ethnicities and races, on any form
1384 provided by such health carrier to collect such ethnic or racial data; and

1385 (II) Not later than February 1, 2022, and annually thereafter, submit a
1386 report to such subsidiary disclosing, in the aggregate, the demographic
1387 data collected by such health carrier pursuant to subparagraph (A)(i)(I)
1388 of this subdivision; and

1389 (ii) Not later than March 1, 2022, and annually thereafter, submit a
1390 report to the exchange disclosing, in the aggregate, the demographic
1391 data that health carriers submitted to such subsidiary pursuant to
1392 subparagraph (A)(i)(II) of this subdivision for the preceding calendar
1393 year;

1394 (B) Seek the state innovation waiver described in subdivision (2) of
1395 subsection (b) of section 16 of this act not later than November 1, 2021;
1396 and

1397 (C) Use the moneys deposited in the Connecticut Health Insurance
1398 Exchange account established under section 13 of this act for the
1399 purposes set forth in subdivision (3) of subsection (b) of section 16 of
1400 this act and, if the exchange uses any funds deposited in said account to
1401 provide premium and cost-sharing subsidies described in
1402 subparagraph (B) of subdivision (3) of subsection (b) of section 16 of this
1403 act, collect, at least annually, demographic data, including, but not
1404 limited to, self-reported ethnic and racial data, concerning the
1405 individuals receiving such subsidies by, at a minimum:

1406 (i) Utilizing standardized categories developed by the Office of
1407 Health Strategy pursuant to subdivision (9) of subsection (b) of section
1408 19a-754a of the general statutes, as amended by this act;

1409 (ii) Including an "other" category and allowing any individual who is
1410 self-reporting ethnic or racial data to write in such individual's ethnicity
1411 or race and select multiple ethnicities and races on any form provided
1412 by the exchange to collect such ethnic or racial data; and

1413 (29) Determine whether individuals referred to the exchange by the
1414 Labor Commissioner pursuant to section 18 of this act are eligible for
1415 free or subsidized health coverage or other assistance or benefits,
1416 including, but not limited to, assistance under the supplemental
1417 nutrition assistance program, and, if such individuals are eligible for
1418 such coverage, assistance or benefits, enroll such individuals in such
1419 coverage, assistance or benefits.

1420 Sec. 12. Section 38a-1089 of the general statutes is repealed and the
1421 following is substituted in lieu thereof (*Effective July 1, 2021*):

1422 (a) Not later than January 1, 2012, and annually thereafter until
1423 January 1, 2014, the chief executive officer of the exchange shall report,
1424 in accordance with section 11-4a, to the Governor and the General

1425 Assembly on a plan, and any revisions or amendments to such plan, to
1426 establish a health insurance exchange in the state. Such report shall
1427 address:

1428 (1) Whether to establish two separate exchanges, one for the
1429 individual health insurance market and one for the small employer
1430 health insurance market, or to establish a single exchange;

1431 (2) Whether to merge the individual and small employer health
1432 insurance markets;

1433 (3) Whether to revise the definition of "small employer" from not
1434 more than fifty employees to not more than one hundred employees;

1435 (4) Whether to allow large employers to participate in the exchange
1436 beginning in 2017;

1437 (5) Whether to require qualified health plans to provide the essential
1438 health benefits package, as described in Section 1302(a) of the
1439 Affordable Care Act, or include additional state mandated benefits;

1440 (6) Whether to list dental benefits separately on the exchange's
1441 Internet web site where a qualified health plan includes dental benefits;

1442 (7) The relationship of the exchange to insurance producers;

1443 (8) The capacity of the exchange to award Navigator grants pursuant
1444 to section 38a-1087;

1445 (9) Ways to ensure that the exchange is financially sustainable by
1446 2015, as required by the Affordable Care Act including, but not limited
1447 to, assessments or user fees charged to carriers;

1448 (10) Methods to independently evaluate consumers' experience,
1449 including, but not limited to, hiring consultants to act as secret shoppers;
1450 and

1451 (11) The status of the implementation and administration of the all-
1452 payer claims database program established under section 19a-755a.

1453 (b) Not later than January 1, 2012, and annually thereafter, the chief
1454 executive officer of the exchange shall report, in accordance with section
1455 11-4a, to the Governor and the General Assembly on:

1456 (1) Any private or federal funds received during the preceding
1457 calendar year and, if applicable, how such funds were expended;

1458 (2) The adequacy of federal funds for the exchange prior to January
1459 1, 2015;

1460 (3) The amount and recipients of any grants awarded; and

1461 (4) The current financial status of the exchange.

1462 (c) Not later than April 1, 2022, and annually thereafter, the chief
1463 executive officer of the exchange shall submit a report, in accordance
1464 with section 11-4a, to the joint standing committee of the General
1465 Assembly having cognizance of matters relating to insurance disclosing,
1466 in the aggregate, the demographic data, if any, that:

1467 (1) The subsidiary established pursuant to subparagraph (A) of
1468 subdivision (28) of section 38a-1084, as amended by this act, reported to
1469 the exchange pursuant to subparagraph (A)(ii) of subdivision (28) of
1470 section 38a-1084, as amended by this act, for the preceding calendar
1471 year; and

1472 (2) The exchange collected pursuant to subparagraph (C) of
1473 subdivision (28) of section 38a-1084, as amended by this act, for the
1474 preceding calendar year.

1475 (d) Not later than January 1, 2023, and annually thereafter, the chief
1476 executive officer of the exchange shall submit a report, in accordance
1477 with section 11-4a, to the joint standing committees of the General
1478 Assembly having cognizance of matters relating to appropriations,
1479 human services and insurance regarding expenditures from the
1480 Connecticut Health Insurance Exchange account established under
1481 section 13 of this act for the preceding calendar year and disclosing
1482 whether such funds were sufficient to carry out the purposes set forth

1483 in subdivision (3) of subsection (b) of section 16 of this act for such
1484 preceding calendar year.

1485 Sec. 13. (NEW) (*Effective July 1, 2021*) There is established an account
1486 to be known as the "Connecticut Health Insurance Exchange account"
1487 which shall be a separate, nonlapsing account within the General Fund.
1488 The account shall contain any moneys required by law to be deposited
1489 in the account. Moneys in the account shall be expended by the
1490 exchange for the purposes set forth in subparagraph (C) of subdivision
1491 (28) of section 38a-1084 of the general statutes, as amended by this act.

1492 Sec. 14. (NEW) (*Effective July 1, 2021*) (a) For the purposes of this
1493 section, "individual market" has the same meaning as provided in
1494 Section 1304 of the Affordable Care Act.

1495 (b) Notwithstanding any provision of the general statutes and to the
1496 extent permitted by federal law, each qualified health plan that is
1497 offered through the exchange, in the individual market and at a silver
1498 level of coverage for plan year 2022 or any subsequent plan year shall
1499 provide coverage for the following benefits:

1500 (1) Angiotensin converting enzyme inhibitors for an enrollee who is
1501 diagnosed with congestive heart failure, diabetes or coronary artery
1502 disease by a licensed health care provider who is acting within such
1503 health care provider's scope of practice;

1504 (2) Anti-resorptive therapy for an enrollee who is diagnosed with
1505 osteoporosis or osteopenia by a licensed health care provider who is
1506 acting within such health care provider's scope of practice;

1507 (3) Beta-adrenergic blocking agents for an enrollee who is diagnosed
1508 with congestive heart failure or coronary artery disease by a licensed
1509 health care provider who is acting within such health care provider's
1510 scope of practice;

1511 (4) Blood pressure monitors for an enrollee who is diagnosed with
1512 hypertension by a licensed health care provider who is acting within

1513 such health care provider's scope of practice;

1514 (5) Inhaled corticosteroids and peak flow meters for an enrollee who
1515 is diagnosed with asthma by a licensed health care provider who is
1516 acting within such health care provider's scope of practice;

1517 (6) Insulin and other glucose lowering agents, retinopathy screening,
1518 glucometers and hemoglobin A1C testing for an enrollee who is
1519 diagnosed with diabetes by a licensed health care provider who is acting
1520 within such health care provider's scope of practice;

1521 (7) International normalized ratio testing for an enrollee who is
1522 diagnosed with liver disease or a bleeding disorder by a licensed health
1523 care provider who is acting within such health care provider's scope of
1524 practice;

1525 (8) Low density lipoprotein testing for an enrollee who is diagnosed
1526 with heart disease by a licensed health care provider who is acting
1527 within such health care provider's scope of practice;

1528 (9) Selective serotonin reuptake inhibitors for an enrollee who is
1529 diagnosed with depression by a licensed health care provider who is
1530 acting within such health care provider's scope of practice; and

1531 (10) Statins for an enrollee who is diagnosed with heart disease or
1532 diabetes by a licensed health care provider who is acting within such
1533 health care provider's scope of practice.

1534 (c) Notwithstanding any provision of the general statutes and to the
1535 extent permitted by federal law, each qualified health plan described in
1536 subsection (b) of this section shall:

1537 (1) Have a minimum actuarial value of at least seventy per cent; and

1538 (2) Provide enrollees with access to the broadest provider network
1539 available under the qualified health plans offered by the health carrier
1540 through the exchange.

1541 Sec. 15. Subsections (a) and (b) of section 19a-754a of the general
1542 statutes are repealed and the following is substituted in lieu thereof
1543 (*Effective July 1, 2021*):

1544 (a) There is established an Office of Health Strategy, which shall be
1545 within the Department of Public Health for administrative purposes
1546 only. The department head of said office shall be the executive director
1547 of the Office of Health Strategy, who shall be appointed by the Governor
1548 in accordance with the provisions of sections 4-5 to 4-8, inclusive, with
1549 the powers and duties therein prescribed.

1550 (b) The Office of Health Strategy shall be responsible for the
1551 following:

1552 (1) Developing and implementing a comprehensive and cohesive
1553 health care vision for the state, including, but not limited to, a
1554 coordinated state health care cost containment strategy;

1555 (2) Promoting effective health planning and the provision of quality
1556 health care in the state in a manner that ensures access for all state
1557 residents to cost-effective health care services, avoids the duplication of
1558 such services and improves the availability and financial stability of
1559 such services throughout the state;

1560 (3) Directing and overseeing the State Innovation Model Initiative
1561 and related successor initiatives;

1562 (4) (A) Coordinating the state's health information technology
1563 initiatives, (B) seeking funding for and overseeing the planning,
1564 implementation and development of policies and procedures for the
1565 administration of the all-payer claims database program established
1566 under section 19a-775a, (C) establishing and maintaining a consumer
1567 health information Internet web site under section 19a-755b, and (D)
1568 designating an unclassified individual from the office to perform the
1569 duties of a health information technology officer as set forth in sections
1570 17b-59f and 17b-59g;

1571 (5) Directing and overseeing the Health Systems Planning Unit
1572 established under section 19a-612 and all of its duties and
1573 responsibilities as set forth in chapter 368z; [and]

1574 (6) Convening forums and meetings with state government and
1575 external stakeholders, including, but not limited to, the Connecticut
1576 Health Insurance Exchange, to discuss health care issues designed to
1577 develop effective health care cost and quality strategies; [.]

1578 (7) Annually (A) determining the amount described in subparagraph
1579 (A)(i) of subdivision (1) of subsection (b) of section 9 of this act, and (B)
1580 reporting such amount to the Insurance Commissioner pursuant to
1581 subparagraph (A)(ii) or (B) of subdivision (1) of subsection (b) of section
1582 9 of this act;

1583 (8) Developing a plan pursuant to subsection (b) of section 16 of this
1584 act and submitting a report containing such plan pursuant to subsection
1585 (c) of section 16 of this act; and

1586 (9) Developing standardized categories that enable (A) the
1587 Comptroller to collect demographic data pursuant to subparagraph (D)
1588 of subdivision (1) of subsection (c) of section 2 of this act, (B) health
1589 carriers to collect and submit demographic data pursuant to
1590 subparagraph (A) of subdivision (28) of section 38a-1084, as amended
1591 by this act, and (C) the exchange to collect demographic data pursuant
1592 to subparagraph (C) of subdivision (28) of section 38a-1084, as amended
1593 by this act.

1594 Sec. 16. (NEW) (*Effective July 1, 2021*) (a) For the purposes of this
1595 section:

1596 (1) "Account" means the Connecticut Health Insurance Exchange
1597 account established under section 13 of this act;

1598 (2) "Affordable Care Act" has the same meaning as provided in
1599 section 38a-1080 of the general statutes, as amended by this act;

1600 (3) "Exchange" has the same meaning as provided in section 38a-1080

1601 of the general statutes, as amended by this act;

1602 (4) "Office of Health Strategy" means the Office of Health Strategy
1603 established under section 19a-754a of the general statutes, as amended
1604 by this act; and

1605 (5) "Qualified health plan" has the same meaning as provided in
1606 section 38a-1080 of the general statutes, as amended by this act.

1607 (b) The Office of Health Strategy shall, in consultation with the
1608 exchange, develop a plan for the exchange to:

1609 (1) Establish a subsidiary, in the manner set forth in section 38a-1093
1610 of the general statutes, to create a marketplace for health carriers to offer
1611 affordable health insurance coverage to persons who are ineligible for
1612 coverage under the qualified health plans offered through the exchange;

1613 (2) Seek a state innovation waiver pursuant to Section 1332 of the
1614 Affordable Care Act for the purpose of:

1615 (A) Reducing the cost of health insurance coverage in this state,
1616 including, but not limited to, premiums and cost-sharing for such
1617 coverage; and

1618 (B) Making health insurance coverage available to persons in this
1619 state who are ineligible for coverage under a qualified health plan
1620 offered through the exchange; and

1621 (3) For plan year 2022 and subsequent plan years, use the moneys
1622 deposited in the account to:

1623 (A) Reduce the cost of qualified health plans offered through the
1624 exchange by, among other things:

1625 (i) Eliminating premiums for such qualified health plans for persons
1626 with a household income not exceeding two hundred one per cent of the
1627 federal poverty level;

1628 (ii) Reducing premiums and cost-sharing for such qualified health

1629 plans for persons with a household income exceeding two hundred one
1630 per cent of the federal poverty level; and

1631 (ii) Establishing a reinsurance program, provided the exchange shall
1632 not use more than twenty million dollars in the account to fund the
1633 reinsurance program for any fiscal year;

1634 (B) Make coverage affordable for persons who are ineligible for
1635 coverage under a qualified health plan offered through the exchange by,
1636 among other things, providing premium and cost-sharing subsidies to
1637 such persons which, in the aggregate for all such persons, shall not
1638 exceed twenty-five million dollars per year; and

1639 (C) Implement the provisions of the state innovation waiver
1640 described in subdivision (2) of this subsection if the federal government
1641 issues such waiver for this state.

1642 (c) Not later than August 1, 2021, the Office of Health Strategy shall
1643 submit a report, in accordance with section 11-4a of the general statutes,
1644 to the joint standing committee of the General Assembly having
1645 cognizance of matters relating to insurance. Such report shall contain
1646 the plan developed pursuant to subsection (b) of this section.

1647 (d) Not later than October 1, 2021, the joint standing committee of the
1648 General Assembly having cognizance of matters relating to insurance
1649 shall advise the Office of Health Strategy and the exchange of its
1650 approval or rejection of the plan contained in the report submitted by
1651 the Office of Health Strategy pursuant to subsection (c) of this section. If
1652 the committee does not act on or before said date, said plan shall be
1653 deemed rejected.

1654 (e) The Office of Health Strategy shall consult with the Department
1655 of Social Services and the exchange to determine whether this state
1656 should seek a waiver from the federal government under Section 1115
1657 of the Social Security Act, 42 USC 1315, as amended from time to time,
1658 to reduce costs to moderate and low income families. If, following such
1659 consultation, the Office of Health Strategy determines that this state

1660 should seek such waiver, the Office of Health Strategy may submit a
1661 report, in accordance with section 11-4a of the general statutes, to the
1662 joint standing committees of the General Assembly having cognizance
1663 of matters relating to appropriations, human services and insurance
1664 disclosing such determination and the reasons therefor.

1665 Sec. 17. Subsection (a) of section 17b-261 of the general statutes is
1666 repealed and the following is substituted in lieu thereof (*Effective July 1,*
1667 *2021*):

1668 (a) Medical assistance shall be provided for any otherwise eligible
1669 person whose income, including any available support from legally
1670 liable relatives and the income of the person's spouse or dependent
1671 child, is not more than one hundred forty-three per cent, pending
1672 approval of a federal waiver applied for pursuant to subsection (e) of
1673 this section, of the benefit amount paid to a person with no income
1674 under the temporary family assistance program in the appropriate
1675 region of residence and if such person is an institutionalized individual
1676 as defined in Section 1917 of the Social Security Act, 42 USC 1396p(h)(3),
1677 and has not made an assignment or transfer or other disposition of
1678 property for less than fair market value for the purpose of establishing
1679 eligibility for benefits or assistance under this section. Any such
1680 disposition shall be treated in accordance with Section 1917(c) of the
1681 Social Security Act, 42 USC 1396p(c). Any disposition of property made
1682 on behalf of an applicant or recipient or the spouse of an applicant or
1683 recipient by a guardian, conservator, person authorized to make such
1684 disposition pursuant to a power of attorney or other person so
1685 authorized by law shall be attributed to such applicant, recipient or
1686 spouse. A disposition of property ordered by a court shall be evaluated
1687 in accordance with the standards applied to any other such disposition
1688 for the purpose of determining eligibility. The commissioner shall
1689 establish the standards for eligibility for medical assistance at one
1690 hundred forty-three per cent of the benefit amount paid to a household
1691 of equal size with no income under the temporary family assistance
1692 program in the appropriate region of residence. In determining
1693 eligibility, the commissioner shall not consider as income Aid and

1694 Attendance pension benefits granted to a veteran, as defined in section
1695 27-103, or the surviving spouse of such veteran. Except as provided in
1696 section 17b-277 and section 17b-292, the medical assistance program
1697 shall provide coverage to persons under the age of nineteen with
1698 household income up to one hundred ninety-six per cent of the federal
1699 poverty level without an asset limit and to persons under the age of
1700 nineteen, who qualify for coverage under Section 1931 of the Social
1701 Security Act, with household income not exceeding one hundred
1702 ninety-six per cent of the federal poverty level without an asset limit,
1703 and their parents and needy caretaker relatives, who qualify for
1704 coverage under Section 1931 of the Social Security Act, with household
1705 income not exceeding [one hundred fifty-five] two hundred one per cent
1706 of the federal poverty level without an asset limit. Such levels shall be
1707 based on the regional differences in such benefit amount, if applicable,
1708 unless such levels based on regional differences are not in conformance
1709 with federal law. Any income in excess of the applicable amounts shall
1710 be applied as may be required by said federal law, and assistance shall
1711 be granted for the balance of the cost of authorized medical assistance.
1712 The Commissioner of Social Services shall provide applicants for
1713 assistance under this section, at the time of application, with a written
1714 statement advising them of (1) the effect of an assignment or transfer or
1715 other disposition of property on eligibility for benefits or assistance, (2)
1716 the effect that having income that exceeds the limits prescribed in this
1717 subsection will have with respect to program eligibility, and (3) the
1718 availability of, and eligibility for, services provided by the Nurturing
1719 Families Network established pursuant to section 17b-751b. For
1720 coverage dates on or after January 1, 2014, the department shall use the
1721 modified adjusted gross income financial eligibility rules set forth in
1722 Section 1902(e)(14) of the Social Security Act and the implementing
1723 regulations to determine eligibility for HUSKY A, HUSKY B and
1724 HUSKY D applicants, as defined in section 17b-290. Persons who are
1725 determined ineligible for assistance pursuant to this section shall be
1726 provided a written statement notifying such persons of their ineligibility
1727 and advising such persons of their potential eligibility for one of the
1728 other insurance affordability programs as defined in 42 CFR 435.4.

1729 Sec. 18. (NEW) (*Effective July 1, 2021*) The Labor Commissioner shall,
 1730 within available appropriations, notify individuals applying for
 1731 unemployment compensation benefits under chapter 567 of the general
 1732 statutes that such individuals may be eligible for free or subsidized
 1733 health coverage or other assistance or benefits, including, but not
 1734 limited to, assistance under the supplemental nutrition assistance
 1735 program. The commissioner shall refer such individuals to the exchange
 1736 for the purpose of determining their eligibility for such coverage,
 1737 assistance or benefits and, if such individuals are eligible for such
 1738 coverage, assistance or benefits, enrolling such individuals in such
 1739 coverage, assistance or benefits. For the purposes of this section,
 1740 "exchange" and "qualified health plan" have the same meanings as
 1741 provided in section 38a-1080 of the general statutes, as amended by this
 1742 act.

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| This act shall take effect as follows and shall amend the following sections: | | |
| Section 1 | <i>July 1, 2021</i> | 3-123rrr |
| Sec. 2 | <i>July 1, 2021</i> | New section |
| Sec. 3 | <i>July 1, 2021</i> | New section |
| Sec. 4 | <i>July 1, 2021</i> | 3-123vvv |
| Sec. 5 | <i>July 1, 2021</i> | 19a-7j |
| Sec. 6 | <i>July 1, 2021</i> | 19a-7p |
| Sec. 7 | <i>July 1, 2021</i> | 38a-52 |
| Sec. 8 | <i>July 1, 2021</i> | 38a-1041 |
| Sec. 9 | <i>July 1, 2021</i> | New section |
| Sec. 10 | <i>July 1, 2021</i> | 38a-1080 |
| Sec. 11 | <i>July 1, 2021</i> | 38a-1084 |
| Sec. 12 | <i>July 1, 2021</i> | 38a-1089 |
| Sec. 13 | <i>July 1, 2021</i> | New section |
| Sec. 14 | <i>July 1, 2021</i> | New section |
| Sec. 15 | <i>July 1, 2021</i> | 19a-754a(a) and (b) |
| Sec. 16 | <i>July 1, 2021</i> | New section |
| Sec. 17 | <i>July 1, 2021</i> | 17b-261(a) |
| Sec. 18 | <i>July 1, 2021</i> | New section |