General Assembly **Substitute Bill No. 842**

January Session, 2021

* SB00842FIN 042221 *

AN ACT CONCERNING HEALTH INSURANCE AND HEALTH CARE IN CONNECTICUT.

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

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 Section 3-123rrr of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

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

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

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

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

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

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

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

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

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

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

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

[(7) "Health care coverage type" means the type of health care

coverage offered by nonstate public employers, including, but not limited to, coverage for a nonstate public employee, nonstate public employee plus spouse and nonstate public employee plus family.**]**

Sec. 2. (NEW) (*Effective July 1, 2021*) (a) The Comptroller shall offer to plan participants and beneficiaries in this state under a multiemployer plan, nonprofit employers in this state, their employees and their employees' dependents and small employers in this state, their employees and their employees' dependents coverage under a fully insured group hospitalization, medical, pharmacy and surgical insurance plan developed by the Comptroller to provide coverage for such plan participants, beneficiaries, employers, employees and dependents. Except as otherwise provided in this section, coverage offered by the Comptroller pursuant to this section shall comply with all applicable provisions of title 38a of the general statutes. The administrators of multiemployer plans, nonprofit employers and small employers shall remit to the Comptroller payments for coverage provided pursuant to this section. Such payments shall be equal to the payments paid by the state for state employees covered under the state employee plan, inclusive of any premiums paid by state employees pursuant to the state employee plan, except:

(1) Premium payments may be adjusted to reflect:

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

(B) Geographic area;

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

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

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

(D) Actuarially justified differences in:

(i) Plan design;

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

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

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

(2) Such payments shall be adjusted to include:

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

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

(C) The public health fee assessed by the Insurance Commissioner

against multiemployer plans, nonprofit employers and small employers pursuant to section 19a-7p of the general statutes, as amended by this act, which the Comptroller shall annually collect from the administrators of multiemployer plans, nonprofit employers and small employers, and pay to the Insurance Commissioner, pursuant to section 19a-7p of the general statutes, as amended by this act;

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

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

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

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

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

(B) Include the health enhancement program;

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

(D) Be approved by the Insurance Department and Health Care Cost Containment Committee during public meetings of the Insurance Department and Health Care Cost Containment Committee;

(E) Include coverage for:

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

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

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

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

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

(i) Three years for:

(I) Multiemployer plans; and

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

(ii) One year for small employers.

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

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

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

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

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

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

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

(2) The Comptroller shall:

(A) Retain an independent actuarial firm to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Purchase:

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

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

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

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

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

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

(A) The medical loss ratio for the fully insured group hospitalization, medical, pharmacy and surgical insurance plan developed and offered by the Comptroller pursuant to this section;

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

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

(3) The Comptroller shall prominently display a link to each report card prepared pursuant to subdivision (1) of this subsection on the

Comptroller's Internet web site.

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

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

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

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

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

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

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

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

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

(d) On or before September first, annually, for each fiscal year beginning on or after July 1, 2021, the Comptroller, after receiving any objections to the proposed assessments made by the Comptroller pursuant to this section and making such adjustments as in the Comptroller's opinion may be indicated, shall assess against each multiemployer plan, nonprofit employer or small employer an amount equal to the proposed assessment as so adjusted. The administrator of

each multiemployer plan and each such nonprofit employer and small employer shall pay to the Comptroller, on or before the following December thirty-first and March thirty-first, annually, the proposed assessment due from such multiemployer plan, nonprofit employer or small employer in two equal installments.

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

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

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

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

Sec. 4. (NEW) (*Effective July 1, 2021*) (a) As used in this section:

(1) "Nonprofit employer" has the same meaning as provided in section 3-123aaa of the general statutes;

(2) "Nonstate public employee" has the same meaning as provided in sections 3-123aaa and 3-123rrr of the general statutes, as amended by this act;

(3) "Nonstate public employer" has the same meaning as provided in sections 3-123aaa and 3-123rrr of the general statutes, as amended by this act;

(4) "Partnership plan" means (A) a health care benefit plan offered by the Comptroller to (i) nonstate public employers or nonprofit employers pursuant to section 3-123bbb of the general statutes, (ii) graduate assistants at The University of Connecticut and The University of Connecticut Health Center, (iii) postdoctoral trainees at The University of Connecticut and The University of Connecticut Health Center, (iv) graduate fellows at The University of Connecticut and The University of Connecticut Health Center, and (v) graduate students of The University of Connecticut participating in university-funded internships as part of their graduate program, and (B) a group hospitalization, medical, pharmacy and surgical insurance plan developed by the Comptroller pursuant to (i) subsection (a) of section 3-123sss of the general statutes, or (ii) section 2 of this act;

(5) "State employee plan" means the group hospitalization, medical, pharmacy and surgical insurance plan offered to (A) state employees and retirees pursuant to section 5-259 of the general statutes, and (B) nonstate public employers, their nonstate public employees and, if applicable, their retirees if the Comptroller offers coverage under such plan to nonstate public employers, their nonstate public employees and, if applicable, retirees under sections 3-123rrr to 3-123www, inclusive, of the general statutes, as amended by this act; and

(6) "Third-party administrator" means any person who directly or indirectly underwrites, collects premiums or charges from, or adjusts or settles claims on, residents of this state in connection with health coverage offered or provided by the Comptroller.

(b) Beginning on July 1, 2021, the Auditors of Public Accounts shall audit the books and accounts of the State Comptroller, and any third-party administrator engaged by the State Comptroller, maintained for the partnership plan or plans or the state employee plan and certify the

results to the Governor.

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

(a) As used in this section:

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

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

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

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

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

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

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

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

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

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

(ii) **[**antibiotics**]** Antibiotics necessary for: **[**the**]**

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

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

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

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

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

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

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

[(b) (1) As used in this subsection, (A) "health insurance" means health insurance of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, and (B) "exempt insurer" means a domestic insurer that administers self-insured health benefit plans and is exempt from third-party administrator licensure under subparagraph (C) of

subdivision (11) of section 38a-720 and section 38a-720a.**]**

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

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

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

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

(A) Each domestic insurer **[**,**]** and domestic health care center **[**,**]** described in subparagraph (A) of subdivision (1) of this subsection, and each third-party administrator and exempt insurer described in subparagraph (B) of subdivision (1) of this subsection, shall report to the Insurance Commissioner, on a form designated by **[**said commissioner**]** the Insurance Commissioner, the number of insured or enrolled lives in this state as of the May first immediately preceding for which such domestic insurer, domestic health care center, third-party administrator or exempt insurer **[**is**]** was providing health insurance or administering a self-insured health benefit plan **[**that provides**]** providing coverage of

the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, **[**. Such number shall not include**]** excluding any lives enrolled in Medicare, any medical assistance program administered by the Department of Social Services, workers' compensation insurance or Medicare Part C plans; and

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

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

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

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

[(4)**]** (3) Not later than November first, annually, the Insurance Commissioner shall determine the fee to be assessed for the current fiscal year against each **[**such**]** domestic insurer **[**,**]** and domestic health care center described in subparagraph (A) of subdivision (1) of this subsection, third-party administrator and exempt insurer described in subparagraph (B) of subdivision (1) of this subsection and multiemployer plan, nonprofit employer and small employer described in subparagraph (C) of subdivision (1) of this subsection. Such fee shall be calculated by multiplying the number of lives reported to **[**said

commissioner**]** the Insurance Commissioner pursuant to subparagraph (A) of subdivision **[**(3)**]** (2) of this subsection, and the number of plan participants, beneficiaries, employees and dependents reported to the Insurance Commissioner pursuant to subparagraph (B) of subdivision (2) of this subsection, by a factor, determined annually by **[**said commissioner**]** the Insurance Commissioner as set forth in this subdivision, to fully fund the amount determined under subdivision (1) of subsection **[**(a)**]** (b) of this section, adjusted for a health and welfare fee, by subtracting, if the amount appropriated was more than the amount expended or by adding, if the amount expended was more than the amount appropriated, the amount calculated under subdivision (2) of subsection **[**(a)**]** (b) of this section. The Insurance Commissioner shall determine the factor by dividing the adjusted amount by the sum of the total number of lives reported to **[**said commissioner**]** the Insurance Commissioner pursuant to subparagraph (A) of subdivision **[**(3)**]** (2) of this subsection and the number of plan participants, beneficiaries, employees and dependents reported to the Insurance Commissioner pursuant to subparagraph (B) of subdivision (2) of this subsection.

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

domestic health care center, third-party administrator and exempt insurer shall pay such fee to the Insurance Commissioner, not later than February first, annually.

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

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

[(7)**]** (6) (A) The Insurance Commissioner shall apply an overpayment

of the health and welfare fee by **[**an**]** a domestic insurer, domestic health care center, third-party administrator or exempt insurer, or by the Comptroller on behalf of a multiemployer plan, nonprofit employer or small employer described in subparagraph (C) of subdivision (1) of this subsection, for any fiscal year as a credit against the health and welfare fee due from such domestic insurer, domestic health care center, third-party administrator, **[**or**]** exempt insurer, multiemployer plan, nonprofit employer or small employer for the succeeding fiscal year, subject to an adjustment under subdivision **[**(4)**]** (3) of this subsection: **[**, if:**]**

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

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

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

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

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

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

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

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

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

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

(a) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[(c)**]** (d) Not later than November first, annually, the Insurance Commissioner shall determine the fee to be assessed for the current fiscal year against each **[**such**]** domestic insurer, **[**and**]** domestic health care center, multiemployer plan, nonprofit employer or small employer described in subdivision (1) of subsection (c) of this section. Such fee shall be calculated by multiplying the number of lives reported to **[**said commissioner**]** the Insurance Commissioner pursuant to subparagraph (A) of subdivision **[**(3)**]** (2) of subsection **[**(b)**]** (c) of this section, and the number of plan participants, beneficiaries, employees and dependents reported to the Insurance Commissioner pursuant to subparagraph (B) of subdivision (2) of subsection (c) of this section, by a factor, determined annually by **[**said commissioner**]** the Insurance

Commissioner as set forth in this subsection, to fully fund the aggregate amount determined under subdivision (1) of subsection **[**(a)**]** (b) of this section. The Insurance Commissioner shall determine the factor by dividing the aggregate amount by the sum of the total number of lives reported to **[**said commissioner**]** the Insurance Commissioner pursuant to subparagraph (A) of subdivision **[**(3)**]** (2) of subsection **[**(b)**]** (c) of this section and the number of plan participants, beneficiaries, employees and dependents reported to the Insurance Commissioner pursuant to subparagraph (B) of subdivision (2) of subsection (c) of this section.

[(d)**]** (e) Not later than December first, annually, the Insurance Commissioner shall submit a statement to each **[**such**]** domestic insurer and domestic health care center described in subdivision (1) of subsection (c) of this section, and to the Comptroller for each multiemployer plan, nonprofit employer or small employer described in subdivision (1) of subsection (c) of this section, that includes the proposed fee, identified on such statement as the "Public Health fee", for **[**the**]** such domestic insurer, **[**or**]** domestic health care center, multiemployer plan, nonprofit employer or small employer, calculated in accordance with this section. Not later than December twentieth, annually, **[**any**]** a domestic insurer, **[**or**]** domestic health care center, or the Comptroller acting on behalf of a multiemployer plan, nonprofit employer or small employer, may submit an objection to the Insurance Commissioner concerning the proposed public health fee. The Insurance Commissioner, after making any adjustment that **[**said commissioner**]** the Insurance Commissioner deems necessary, shall, not later than January first, annually, submit a final statement to the Comptroller for each multiemployer plan, nonprofit employer and small employer described in subdivision (1) of subsection (c) of this section that includes the final fee for such multiemployer plan, nonprofit employer or small employer and to each domestic insurer and domestic health care center that includes the final fee for **[**the**]** such domestic insurer or domestic health care center. **[**Each such**]** The Comptroller shall collect such fee from each such multiemployer plan, nonprofit employer and small employer and pay such fee to the Insurance

Commissioner, and each such domestic insurer and domestic health care center shall pay such fee to the Insurance Commissioner, not later than February first, annually.

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

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

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

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

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

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

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

(A) **[**determine**]** Determine whether the domestic insurer, **[**or**]** domestic health care center, multiemployer plan, nonprofit employer or small employer made an overpayment; **[**,**]** and

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

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

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

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

Any (1) domestic insurance company or other domestic entity aggrieved because of any assessment levied under section 38a-48, (2) fraternal benefit society or foreign or alien insurance company or other entity aggrieved because of any assessment levied under the provisions of sections 38a-49 to 38a-51, inclusive, **[**or**]** (3) domestic insurer, domestic health care center **[**,**]** or third-party administrator licensed pursuant to section 38a-720a, or exempt insurer, administrator of a multiemployer plan, nonprofit employer or small employer as defined in **[**subdivision (1) of**]** subsection **[**(b)**]** (a) of section 19a-7j, as amended by this act, aggrieved because of any assessment levied under said section 19a-7j, as amended by this act, or (4) domestic insurer or domestic health care center, or administrator of a multiemployer plan, nonprofit employer or

small employer as defined in subsection (a) of section 19a-7p, as amended by this act, aggrieved because of any assessment levied under said section 19a-7p, as amended by this act, may, within one month from the time provided for the payment of such assessment, appeal therefrom to the superior court for the judicial district of New Britain, which appeal shall be accompanied by a citation to the commissioner to appear before said court. Such citation shall be signed by the same authority, and such appeal shall be returnable at the same time and served and returned in the same manner, as is required in case of a summons in a civil action. The authority issuing the citation shall take from the appellant a bond or recognizance to the state, with surety to prosecute the appeal to effect and to comply with the orders and decrees of the court in the premises. Such appeals shall be preferred cases, to be heard, unless cause appears to the contrary, at the first session, by the court or by a committee appointed by the court. Said court may grant such relief as may be equitable, and, if such assessment has been paid prior to the granting of such relief, may order the Treasurer to pay the amount of such relief, with interest at the rate of six per cent per annum, to the aggrieved company. If the appeal has been taken without probable cause, the court may tax double or triple costs, as the case demands; and, upon all such appeals which may be denied, costs may be taxed against the appellant at the discretion of the court, but no costs shall be taxed against the state.

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

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

(b) The Office of the Healthcare Advocate may:

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

services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) On or before October 1, 2008, the Office of the Healthcare Advocate shall, within available appropriations, establish and maintain a healthcare consumer information web site on the Internet for use by the

public in obtaining healthcare information, including but not limited to: (1) The availability of wellness programs in various regions of Connecticut, such as disease prevention and health promotion programs; (2) quality and experience data from hospitals licensed in this state; and (3) a link to the consumer report card developed and distributed by the Insurance Commissioner pursuant to section 38a-478*l*.

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

(h) The Office of the Healthcare Advocate shall provide assistance to the plan participants and beneficiaries in this state under multiemployer plans, nonprofit employers' employees and their dependents and small employers' employees and their dependents receiving coverage provided by the Comptroller pursuant to section 2 of this act that is equivalent to the assistance that the Office of the Healthcare Advocate provides to other health insurance consumers.

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

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

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

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

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

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

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

(i) Determine the amount that the exchange requires to perform its

duties under subparagraph (C) of subdivision (28) of section 38a-1084 of the general statutes, as amended by this act; and

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

(B) Not later than July 1, 2021, report to the Insurance Commissioner that the amount described in subparagraph (A)(i) of this subdivision is fifty million dollars for the year 2022.

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

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

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

(3) Not later than August 1, 2021, and annually thereafter, the commissioner shall determine the fee to be assessed for that year against each insurer, health care center and exempt insurer described in

subdivision (1) of this subsection. Such fee shall be determined by multiplying the number of insured or enrolled lives reported to the commissioner pursuant to subdivision (2) of this subsection by a factor, determined annually by the commissioner, to fully fund the amount reported by the Office of Health Strategy to the commissioner pursuant to subparagraph (A)(ii) or (B) of subdivision (1) of subsection (b) of this section. The commissioner shall determine the factor by dividing the amount reported by the Office of Health Strategy to the commissioner pursuant to subparagraph (A)(ii) or (B) of subdivision (1) of subsection (b) of this section by the total number of insured or enrolled lives reported to the commissioner pursuant to subdivision (2) of this subsection.

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

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

(5) Any insurer, health care center or exempt insurer that fails to file the report required under subdivision (2) of this subsection, or pay the fee assessed under subdivision (1) of this subsection, shall pay a late filing or payment fee, as applicable, of one hundred dollars per day for each day from the date such report or payment was due. The commissioner shall deposit all late fees paid pursuant to this subdivision in the Connecticut Health Insurance Exchange account. The commissioner may require an insurer, health care center or exempt

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

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

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

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

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

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

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

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

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

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

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

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

(e) The Insurance Commissioner may adopt regulations, in

accordance with chapter 54 of the general statutes, to implement the provisions of this section.

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

For purposes of this section, sections **[**38a-1080**]** 38a-1081 to 38a-1093, inclusive, and sections 13 and 14 of this act:

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

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

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

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

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

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

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

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

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

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

(iv) Workers' compensation insurance;

(v) Automobile medical payment insurance;

(vi) Credit insurance;

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

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

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

(i) Limited scope dental or vision benefits;

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

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

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

(D) "Health benefit plan" does not include coverage of the type specified in subdivisions (3) and (13) of section 38a-469 or other fixed indemnity insurance if (i) such coverage is provided under a separate insurance policy, certificate or contract, (ii) there is no coordination

between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and (iii) the benefits are paid with respect to an event without regard to whether benefits were also provided under any group health plan maintained by the same plan sponsor;

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

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

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

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

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

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

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

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

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

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

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

The exchange shall:

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

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

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

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

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

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

(7) Publish the average costs of licensing, regulatory fees and any other payments required by the exchange and the administrative costs

of the exchange, including information on moneys lost to waste, fraud and abuse, on an Internet web site to educate individuals on such costs;

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

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

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

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

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

(13) Establish a program for small employers through which

qualified employers may access coverage for their employees and that shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the exchange at the specified level of coverage;

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

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

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

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

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

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

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

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

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

(C) The name and taxpayer identification number of:

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

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

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

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

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

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

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

(C) Facilitate enrollment in qualified health plans;

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

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

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

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

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

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

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

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

(D) The Department of Social Services; and

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

(23) Meet the following financial integrity requirements:

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

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

(i) Investigate the affairs of the exchange;

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

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

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

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

exchange; **[**and**]**

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

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

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

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

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

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

(I) Collect demographic data, including, but not limited to, self-reported ethnic and racial data, concerning the individuals receiving such coverage by, at a minimum, utilizing standardized categories developed by the Office of Health Strategy pursuant to subdivision (9) of subsection (b) of section 19a-754a of the general statutes, as amended by this act, including an "other" category and allowing any individual

who is self-reporting ethnic or racial data to write in such individual's ethnicity or race, and select multiple ethnicities and races, on any form provided by such health carrier to collect such ethnic or racial data; and

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

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

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

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

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

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

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

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

(a) Not later than January 1, 2012, and annually thereafter until January 1, 2014, the chief executive officer of the exchange shall report, in accordance with section 11-4a, to the Governor and the General Assembly on a plan, and any revisions or amendments to such plan, to establish a health insurance exchange in the state. Such report shall address:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) The current financial status of the exchange.

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

(1) The subsidiary established pursuant to subparagraph (A) of subdivision (28) of section 38a-1084, as amended by this act, reported to

the exchange pursuant to subparagraph (A)(ii) of subdivision (28) of section 38a-1084, as amended by this act, for the preceding calendar year; and

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

(d) Not later than January 1, 2023, and annually thereafter, the chief executive officer of the exchange shall submit a report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, human services and insurance regarding expenditures from the Connecticut Health Insurance Exchange account established under section 13 of this act for the preceding calendar year and disclosing whether such funds were sufficient to carry out the purposes set forth in subdivision (3) of subsection (b) of section 16 of this act for such preceding calendar year.

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

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

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

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

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

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

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

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

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

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

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

(9) Selective serotonin reuptake inhibitors for an enrollee who is

diagnosed with depression by a licensed health care provider who is acting within such health care provider's scope of practice; and

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

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

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

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

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

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

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

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

(2) Promoting effective health planning and the provision of quality health care in the state in a manner that ensures access for all state

residents to cost-effective health care services, avoids the duplication of such services and improves the availability and financial stability of such services throughout the state;

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

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

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

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

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

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

(9) Developing standardized categories that enable (A) the

Comptroller to collect demographic data pursuant to subparagraph (D) of subdivision (1) of subsection (c) of section 2 of this act, (B) health carriers to collect and submit demographic data pursuant to subparagraph (A) of subdivision (28) of section 38a-1084, as amended by this act, and (C) the exchange to collect demographic data pursuant to subparagraph (C) of subdivision (28) of section 38a-1084, as amended by this act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) Reducing premiums and cost-sharing for such qualified health plans for persons with a household income exceeding two hundred one per cent of the federal poverty level; and

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

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

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

(c) Not later than August 1, 2021, the Office of Health Strategy shall

submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance. Such report shall contain the plan developed pursuant to subsection (b) of this section.

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

(e) The Office of Health Strategy shall consult with the Department of Social Services and the exchange to determine whether this state should seek a waiver from the federal government under Section 1115 of the Social Security Act, 42 USC 1315, as amended from time to time, to reduce costs to moderate and low income families. If, following such consultation, the Office of Health Strategy determines that this state should seek such waiver, the Office of Health Strategy may submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, human services and insurance disclosing such determination and the reasons therefor.

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

(a) Medical assistance shall be provided for any otherwise eligible person whose income, including any available support from legally liable relatives and the income of the person's spouse or dependent child, is not more than one hundred forty-three per cent, pending approval of a federal waiver applied for pursuant to subsection (e) of this section, of the benefit amount paid to a person with no income under the temporary family assistance program in the appropriate

region of residence and if such person is an institutionalized individual as defined in Section 1917 of the Social Security Act, 42 USC 1396p(h)(3), and has not made an assignment or transfer or other disposition of property for less than fair market value for the purpose of establishing eligibility for benefits or assistance under this section. Any such disposition shall be treated in accordance with Section 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of property made on behalf of an applicant or recipient or the spouse of an applicant or recipient by a guardian, conservator, person authorized to make such disposition pursuant to a power of attorney or other person so authorized by law shall be attributed to such applicant, recipient or spouse. A disposition of property ordered by a court shall be evaluated in accordance with the standards applied to any other such disposition for the purpose of determining eligibility. The commissioner shall establish the standards for eligibility for medical assistance at one hundred forty-three per cent of the benefit amount paid to a household of equal size with no income under the temporary family assistance program in the appropriate region of residence. In determining eligibility, the commissioner shall not consider as income Aid and Attendance pension benefits granted to a veteran, as defined in section 27-103, or the surviving spouse of such veteran. Except as provided in section 17b-277 and section 17b-292, the medical assistance program shall provide coverage to persons under the age of nineteen with household income up to one hundred ninety-six per cent of the federal poverty level without an asset limit and to persons under the age of nineteen, who qualify for coverage under Section 1931 of the Social Security Act, with household income not exceeding one hundred ninety-six per cent of the federal poverty level without an asset limit, and their parents and needy caretaker relatives, who qualify for coverage under Section 1931 of the Social Security Act, with household income not exceeding **[**one hundred fifty-five**]** two hundred one per cent of the federal poverty level without an asset limit. Such levels shall be based on the regional differences in such benefit amount, if applicable, unless such levels based on regional differences are not in conformance with federal law. Any income in excess of the applicable amounts shall

be applied as may be required by said federal law, and assistance shall be granted for the balance of the cost of authorized medical assistance. The Commissioner of Social Services shall provide applicants for assistance under this section, at the time of application, with a written statement advising them of (1) the effect of an assignment or transfer or other disposition of property on eligibility for benefits or assistance, (2) the effect that having income that exceeds the limits prescribed in this subsection will have with respect to program eligibility, and (3) the availability of, and eligibility for, services provided by the Nurturing Families Network established pursuant to section 17b-751b. For coverage dates on or after January 1, 2014, the department shall use the modified adjusted gross income financial eligibility rules set forth in Section 1902(e)(14) of the Social Security Act and the implementing regulations to determine eligibility for HUSKY A, HUSKY B and HUSKY D applicants, as defined in section 17b-290. Persons who are determined ineligible for assistance pursuant to this section shall be provided a written statement notifying such persons of their ineligibility and advising such persons of their potential eligibility for one of the other insurance affordability programs as defined in 42 CFR 435.4.

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

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

INS *Joint Favorable Subst. C/R* FIN

FIN *Joint Favorable*