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sSB-1
AN ACT CONCERNING THE HEALTH AND SAFETY OF CONNECTICUT RESIDENTS.

AMENDMENT

LCO No.: 5345
File Copy No.: 315
Senate Calendar No.: 196

OFA Fiscal Note

See Fiscal Note Details

The amendment strikes the language in the underlying bill and the associated fiscal impact. The fiscal impact to the state and municipalities is described below.

Sections 2 and **5** may result in savings to the Department of Social Services (DSS) to the extent that certain health care providers do not meet workplace health and safety and violence prevention standards specified by the amendment. Certain providers must submit evidence of adoption and implementation of such standards as a condition of receiving payment for services provided under Medicaid and HUSKY B.

Section 2 may also result in increased costs to DSS associated with enhanced rates to entities for timely reporting of any workplace violence incidents. The extent of the cost is dependent on the value of the enhanced rate, the facilities eligible for the timely reporting enhancements, and the discretion of the commissioner.

Section 4 results in a cost to DSS associated with providing incentive grants for home health care agencies to provide (1) escorts for safety purposes to staff members conducting a home visit, and (2) a mechanism for staff to perform safety checks. While the amendment

requires DSS to establish the home health worker safety grant program by 1/1/25, they must provide grants by 1/1/27. The extent of the cost depends on available funding and the parameters of such program to be defined by DSS.

Sections 18 - 19 result in a potential cost to the state and municipalities associated with requiring individual and group health insurance policies to provide coverage for coronary calcium scans.

The amendment results in costs to the State Comptroller – Fringe Benefits account of up to $269,000 beginning in FY 25, and annually thereafter, subject to premium increases for the state employee health insurance plan (SEHP) for the newly mandated coverage requirements.[1] Premiums for the SEHP are anticipated to increase by $0.15 PMPM. annually beginning in FY 25. Based on FY 23 claims data across commercial and state plans, the average allowable amount payable by insurance companies is $160. The cost analysis assumes approximately a 7% utilization rate in the estimated eligible population.

These sections additionally result in costs to municipalities participating in the state Partnership Plan (SPP) of up to $32,000 beginning in FY 25 and annually thereafter, subject to premium increases for the newly mandated coverage requirements.[2] Fully insured municipalities and those in the Partnership Plan are anticipated to incur costs at a rate of $0.15 PMPM for the required coverage of coronary calcium scans.

Municipalities with fully insured health plans will also see costs to the extent their plans do not currently offer coverage for the provisions outlined above. Due to federal law, the coverage requirements will not apply to self-insured municipalities, as they are exempt under

[1] Coverage requirements as outlined in the amendment begin on January 1, 2025. However, SEHP and SPP premium rates run on a fiscal year basis, beginning July 1. The fiscal impact above assumes the coverage requirements will be rolled into the plan at the start of the next renewal period.

[2] The cost estimate is for the Partnership Plan rates generally. Each municipality would bear different levels of the overall cost dependent on their number of enrollees.

Employee Retirement Income Security Act (ERISA).

Sections 18 and **19** also result in a potential cost to the state of up to $117,000 in FY 25 and up to $234,000 in FY 26 (and annually thereafter) to defray additional premium costs for enrollees purchasing health insurance on the state's exchange. This cost is potential as it is incurred to the extent the new coverage requirement for coronary calcium scans is determined to increase premiums and constitute a new state benefit mandate under the federal Affordable Care Act (ACA). It is not currently covered for most enrollees.

Under the ACA, states are allowed to mandate benefits beyond the essential health benefits but must pay for that excess coverage. Federal regulations require the state to defray the cost of additional benefits related to specific care, treatment or services mandated by state action after December 31, 2011 (except to comply with federal requirements) for all plans sold on the exchange.[3] There are currently 130,141 enrollees in qualified health plans on the exchange, including 29,687 in Covered Connecticut.

To the extent the amendment is determined to include a new state benefit mandate that requires defrayal, there would be a cost to the state beginning January 1, 2025.[4] Full year costs would begin in FY 26 and continue annually.

Defrayal costs for Covered Connecticut enrollees would be incurred by the Department of Social Services (DSS), to the extent the amendment raises premiums for those enrollees. It is not clear how or when the ACA defrayal rules will be enforced for non-Covered Connecticut enrollees.

Insurance coverage for coronary calcium scans, which typically cost between $100 and $200 per scan, is estimated to increase premiums by

[3] 45 CFR 155.170

[4]After determining if the mandate is subject to defrayal, states must reimburse the carriers or the insureds for the excess coverage. The premium costs are to be quantified by each insurer on the exchange and reported to the state.

$0.15 PMPM. The actual increase to premiums will be calculated by insurers offering exchange plans and will depend on the utilization rate, which is expected to increase once it becomes a covered service. DSS would incur approximately 23% of those total defrayal costs on behalf of Covered Connecticut enrollees.

Sections 26 tasks DPH with operating a statewide data registry on Parkinson's disease and Parkinsonism by 4/1/26, which is anticipated to result in a state cost of approximately $610,062 in FY 26 and $492,369 in FY 27 and the out years. This estimate includes the salaries of a full-time Epidemiologist II and a half-time Data Scientist, their fringe benefits, and necessary initial ($500,000) and on-going ($300,000) data registry information technology expenses.

Section 27 is not anticipated to result in a fiscal impact as the Department of Mental Health and Addiction Services (DMHAS) currently operates the Specialized Treatment in Early Psychosis (STEP) program statewide, utilizing state and federal funds.

Sections 32 - 33 result in a potential cost to the State Comptroller – Fringe Benefits account for the state employee health plan from the anticipated increase in administrative costs and utilization of medical services. Administrative costs are expected to increase from the redefinition of "clinical peer," which would require carriers to contract specialists at a rate of $700 per peer. Claims costs may also increase as clinical peers have the authority to reverse adverse determinations resulting from the change in utilization review methodology.

Self and fully insured municipalities as well as those enrolled in the Partnership plan may see an increase in premiums to the extent carriers expect to see higher utilization of services and face higher costs for evaluating adverse determination appeals. Due to federal law, self-insured health plans are exempt from state health insurance benefit mandates, so potential costs are contingent on the plan electing to adopt the mandate.

To the extent that the bill results in additional medical services

provided by the University of Connecticut Health Center, there could be a clinical revenue increase beginning in FY 25.

Section 34 prohibits prior authorization for medically necessary transport to a hospital by ambulance and is not anticipated to result in a fiscal impact as this coverage is in line with that of the state employee and Partnership plans. Fully insured municipalities can face costs to the extent carriers currently require prior authorization for this service.

Section 36 results in a cost to DMHAS to establish a peer-run respite center. Effective 10/1/24, DMHAS must contract with a nonprofit peer-run organization to operate the center and report on the program by 10/1/25. Based on a recent, similar request for proposal (RFP), this is anticipated to result in a cost to the state of approximately $500,000-$650,000 annually.

The amendment makes various other changes that have no fiscal impact to the state or municipalities.