General Assembly

Substitute Bill No. 984

January Session, 2019

SB00984INS 032019

AN ACT CONCERNING MINIMUM ESSENTIAL HEALTH COVERAGE, REPORTS REGARDING HEALTH INSURANCE AND TAXATION, A HEALTH INSURER SURCHARGE AND THE CONNECTICUT HEALTH INSURANCE EXCHANGE.

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

Section 1. (NEW) (*Effective January 1, 2020*) (a) For the purposes of this section, unless the context otherwise requires:

(1) "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time.

(2) "Applicable individual" means, with respect to any month, an individual who (A) is a citizen or national of the United States or an alien lawfully present in the United States, (B) is not a member of an Indian tribe as defined in Section 45A(c)(6) of the Internal Revenue Code, (C) is not incarcerated, unless such individual is incarcerated pending the disposition of charges, and (D) has not received an exemption from the exchange pursuant to subdivision (15) of section 38a-1084 of the general statutes, as amended by this act, because such individual has not certified that such individual is (i) a member of a recognized religious sect or division thereof described in Section 1402(g)(1) of the Internal Revenue Code and an adherent of the established tenets or teachings of such religious sect or division, or (ii) a member of a religious sect or division thereof that is not described in

said section, relies solely on a religious method of healing and for whom the acceptance of medical health services would be inconsistent with such individual's religious beliefs.

(3) "Dependent" has the same meaning as provided in Section 152 of the Internal Revenue Code.

(4) (A) "Minimum essential coverage" means (i) coverage under the Medicare program under Part A or C of Title XVIII of the Social Security Act, (ii) coverage under the Medicaid program under Title XIX of the Social Security Act, (iii) coverage under the Children's Health Insurance Program under Title XXI of the Social Security Act, (iv) medical coverage under 10 USC Chapter 55, including, but not limited to, coverage under the TriCare program, (v) coverage under a health care program under 38 USC Chapter 17 or 18, (vi) coverage for United States Peace Corps volunteers under 22 USC 2504(e), (vii) coverage under the Nonappropriated Fund Health Benefits Program of the United States Department of Defense established under Section 349 of the National Defense Authorization Act for Fiscal Year 1995, P.L. 103-337, (viii) coverage under an eligible employer-sponsored plan, (ix) coverage under a health plan offered in the individual market as defined in Section 1304 of the Affordable Care Act, (x) coverage under a grandfathered health plan, as that term is used in the Affordable Care Act, or (xi) coverage under any other qualified health plan, as that term is used in Section 1311(c) of the Affordable Care Act.

(B) "Minimum essential coverage" does not mean any health insurance coverage that consists of coverage of excepted benefits described in (i) Section 2791(c)(1) of the Public Health Service Act, 42 USC 300gg-91(c)(1), as amended by the Affordable Care Act, or (ii) Section 2791(c)(2), (3) or (4) of the Public Health Service Act, 42 USC 300gg-91(c)(2), (3) or (4), as amended by the Affordable Care Act, if such benefits are provided under a separate policy, certificate or contract of insurance.

(5) "Resident of this state" has the same meaning as provided in

section 12-701 of the general statutes.

(6) "Taxpayer" means a resident of this state who is a taxpayer within the meaning of Section 5000A of the Internal Revenue Code.

(b) (1) Each taxpayer shall, for each month beginning on or after January 1, 2020, ensure that such taxpayer, if such taxpayer is an applicable individual, and each dependent of such taxpayer, if such dependent is an applicable individual, maintains minimum essential coverage.

(2) For the purposes of subdivision (1) of this subsection, an applicable individual shall be deemed to have maintained minimum essential coverage for any month during which the applicable individual is not a resident of this state if:

(A) Such month occurs during any period described in Section 911(d)(1)(A) or (B) of the Internal Revenue Code that is applicable to such applicable individual;

(B) Such applicable individual is a bona fide resident of any possession of the United States, as determined under Section 937(a) of the Internal Revenue Code, for such month; or

(C) Such applicable individual is a bona fide resident of any other state of the United States for such month.

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

Sec. 2. (*Effective July 1, 2019*) Not later than October 1, 2019, the Commissioner of Revenue Services, in consultation with the Insurance Commissioner, the executive director of the Office of Health Strategy and the exchange established pursuant to section 38a-1081 of the general statutes, 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 include the commissioner's recommendations concerning: (1) Measures to enforce the provisions of section 1 of this act, including, but not limited to, a state individual health care responsibility fee that is designed to ensure that taxpayers and dependents maintain minimum essential coverage, as those terms are defined in said section; and (2) a refundable credit against the personal income tax imposed under chapter 229 of the general statutes to help residents of this state, as defined in section 12-701 of the general statutes, offset the cost of health insurance.

Sec. 3. (NEW) (*Effective July 1, 2019*) (a) For each calendar month beginning on or after January 1, 2020, each insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity delivering, issuing for delivery, renewing, amending or continuing in this state an individual or group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes shall remit to the Insurance Commissioner, in a form and manner prescribed by the commissioner, a surcharge for each policy providing such coverage during such month or any portion of such month. The amount of such surcharge shall be calculated as follows:

(1) If such policy is an individual health insurance policy, ten dollars multiplied by the number of insureds under such policy; or

(2) If such policy is a group health insurance policy, five dollars multiplied by the number of insureds under such policy.

(b) The monthly surcharge imposed under subsection (a) of this section shall not be considered premium for any purpose, and no portion of such surcharge shall be refundable or borne by an insured.

(c) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or

entity shall remit to the Insurance Commissioner, not later than the thirtieth day of April annually, all monthly surcharges imposed on such company, society, corporation, center or entity under subsection (a) of this section for the calendar year immediately preceding. Each remittance shall include documentation, in a form and manner prescribed by the commissioner, to substantiate the amount of the monthly surcharges being remitted by such company, society, corporation, center or entity.

(d) Not later than the first day of June annually, the Insurance Commissioner shall deposit all remittances for the calendar year immediately preceding in the Connecticut Health Insurance Exchange Fund established pursuant to section 5 of this act.

(e) The surcharge imposed under subsection (a) of this section shall constitute a special purpose assessment for the purposes of section 12-211 of the general statutes.

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

Sec. 4. Section 38a-1080 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

For purposes of sections 38a-1080 to 38a-1093, inclusive<u>, as amended by this act, and section 5 of this act</u>:

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

(2) "Commissioner" means the Insurance Commissioner;

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

(4) "Affordable Care Act" means the Patient Protection and

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

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

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

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

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

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

(iv) Workers' compensation insurance;

(v) Automobile medical payment insurance;

(vi) Credit insurance;

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

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

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

(i) Limited scope dental or vision benefits;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 5. (NEW) (*Effective July 1, 2019*) The exchange shall establish and administer a fund, to be known as the "Connecticut Health Insurance Exchange Fund", to provide funding for (1) state-financed health insurance premium and cost-sharing subsidies to individuals in this state, and (2) a reinsurance program for the purpose of decreasing the cost of health insurance in this state. The fund shall contain any moneys required by law to be deposited in the fund and shall be accounted for separately from all other moneys, funds and accounts.

Sec. 6. Section 38a-1084 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

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

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

(B) Grant a certification, subject to section 1 of this act, attesting that, for purposes of said section, an individual is exempt from the requirement that the individual maintain minimum essential coverage pursuant to said section because such individual meets the requirements for an exemption from such requirement;

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

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

[(B)**]** (ii) 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)**]** (I) The employer did not provide minimum essential health benefits coverage; or

[(ii)**]** (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)**]** (iii) The name and taxpayer identification number of:

[(i)**]** (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)**]** (II) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

(B) Provide to the Commissioner of Revenue Services the following:

(i) The information described in subparagraph (A) of this subdivision; and

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

(17) Provide to each employer the name of each employee, as described in subparagraph **[**(B)**]** (A)(ii) 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; **[**.**]** and

(26) Establish and administer the "Connecticut Health Insurance Exchange Fund" pursuant to section 5 of this act.

Sec. 7. (NEW) (*Effective October 1, 2019*) (a) For the purposes of this section:

(1) "Exchange" means the Connecticut Health Insurance Exchange established pursuant to section 38a-1081 of the general statutes;

(2) "Plan year" has the same meaning as that term is used in section 38a-1084 of the general statutes, as amended by this act; and

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

(b) Each insurer, health care center, fraternal benefit society, hospital

service corporation, medical service corporation or other entity that delivers, issues for delivery, renews, amends or continues not fewer than five thousand individual or group health insurance policies in this state that provide coverage of the type specified in subdivision (1), (2), (4), (11) or (12) of section 38a-469 of the general statutes during a calendar year beginning on or after January 1, 2020, shall, for the immediately following plan year, offer not fewer than one qualified health plan through the exchange.

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

Sec. 8. Subdivisions (1) and (2) of subsection (m) of section 5-259 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

(m) (1) Notwithstanding any provision of the general statutes, the Comptroller shall begin procedures to convert the group hospitalization and medical and surgical insurance plans set forth in subsection (a) of this section, including any prescription drug plan offered in connection with or in addition to such insurance plans, to self-insured plans, except that any dental plan offered in connection with or in addition to such self-insured plans may be fully insured.

(2) The Comptroller may enter into contracts with third-party administrators to provide administrative services only for the self-insured plans set forth in subdivision (1) of this subsection. Any such third-party administrator shall be required under such contract to: **[**charge**]**

(A) Charge such third-party administrator's lowest available rate for such services; **[**.**]** and

(B) Offer not fewer than one qualified health plan, as defined in section 38a-1080, as amended by this act, through the exchange established pursuant to section 38a-1081 for each plan year, as that

term is used in section 38a-1084, as amended by this act, during the term of such contract if:

(i) Such contract is entered into, renewed or amended on or after October 1, 2019;

(ii) Such plan year begins on or after January 1, 2020, and on or after the date that such contract is entered into, renewed or amended; and

(iii) Such third-party administrator is an insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity that (I) is authorized to transact health insurance business in this state, and (II) delivered, issued for delivery, renewed, amended or continued not fewer than five thousand individual or group health insurance policies in this state that provided coverage of the type specified in subdivision (1), (2), (4), (11) or (12) of section 38a-469 during the calendar year immediately preceding such plan year.

Sec. 9. (*Effective July 1, 2019*) Not later than October 1, 2019, the Office of Health Strategy, in consultation with the Insurance Commissioner, the Healthcare Advocate, the Connecticut Health Insurance Exchange established pursuant to section 38a-1081 of the general statutes and the insurance industry, 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 include the Office of Health Strategy's recommendations concerning the implementation of state-financed health insurance premium and cost-sharing subsidies and a reinsurance program for the purpose of decreasing the cost of health insurance in this state.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2020*	New section
Sec. 2	*July 1, 2019*	New section

Sec. 3	*July 1, 2019*	New section
Sec. 4	*July 1, 2019*	38a-1080
Sec. 5	*July 1, 2019*	New section
Sec. 6	*July 1, 2019*	38a-1084
Sec. 7	*October 1, 2019*	New section
Sec. 8	*October 1, 2019*	5-259(m)(1) and (2)
Sec. 9	*July 1, 2019*	New section

Statement of Legislative Commissioners:

In Section 7(b), "subdivision" was substituted for "subdivisions" and "or" was substituted for "and" for clarity; in Section 8(m)(2)(B), "that term is" was deleted for conciseness; and in Section 8(m)(2)(B)(iii), "subdivision" was substituted for "subdivisions" and "or" was substituted for "and" for clarity.

INS *Joint Favorable Subst.*