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SB-10
AN ACT CONCERNING HEALTH INSURANCE AND PATIENT PROTECTION.

AMENDMENT

LCO No.: 8138
File Copy No.: 419
Senate Calendar No.: 241

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 26 $	FY 27 $
State Comptroller - Fringe Benefits; Various State Agencies	App Fund - Potential Cost	See Below	See Below
State Comptroller - Fringe Benefits; Various State Agencies	App Fund - Potential Savings	See Below	See Below
Insurance Dept.	GF - Potential Revenue Gain	See Below	See Below
UConn Health Ctr.	OF - Revenue Gain/Loss	See Below	See Below

Note: App Fund=All Appropriated Funds; GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 26 $	FY 27 $
Various Municipalities	Potential Cost	See Below	See Below
Various Municipalities	Potential Savings	See Below	See Below

Explanation

The amendment strikes the underlying bill and its associated fiscal impacts. The amendment results in various fiscal impacts described by section below.

Sections 1 and 2 require each health carrier to annually certify their

review of compliance with mental health and substance use disorder benefit reporting requirements to the Insurance Commissioner, who must make these reports, including the names of health carriers, public. These procedural changes result in no fiscal impact.

Section 3 allows the Insurance Department to impose civil penalties on health carriers for failing to comply with certain specified reporting and mental health parity requirements. Health carriers can be fined $100 per participant, up to $1 million in aggregate annually, resulting in a potential revenue gain to the General Fund, beginning in FY 26 and annually thereafter. Health carriers may also be fined for late filings. The resulting revenue gain will depend on the number of violations and the department's discretion to pursue civil penalties. The section additionally allows the Insurance Department to order payment to cover the department's reasonable expenses for proceedings, which is expected to defray any such costs.

Sections 4 and 5 prohibit the use of step therapy for the treatment of: (1) a disability expected to last five or more years, or (2) a mental or behavioral health condition.

There is a potential half-year cost in FY 26, annualized in FY 27 at approximately $8.5 million (and annually thereafter) across various state funds for restriction (1) on step therapy on the state employee health plan (SEHP). Approximately $4.8 million of these costs are borne by the State Comptroller – Fringe Benefits account within General Fund. Actual costs are dependent on the impact to premiums for the SEHP resulting from increased prescription drug costs. The use of specialty drugs is a significant cost driver of the state employee health plan and state partnership plan (SPP). The restriction on prescription drugs used to treat a mental or behavioral health condition does not result in a fiscal impact as the plan does not currently use step therapy on these conditions.

These sections also result in potential costs to various municipalities that either have fully insured health plans or participate in the SPP to the extent higher utilization and prescription drug costs increase plan

premiums. The SPP would face costs commensurate with the increase to the state employee health plan based on their enrollment.

Sections 6 and 7 gives the commissioner of the Insurance Department the authority to reduce insurance rate premiums for certain fully insured plans and Exchange plans if the increase is above the health care cost growth benchmark, which results in no fiscal impact to the state. This is a procedural change within the existing rate review process.

Sections 8 and 9 prohibit health insurance policies from placing certain limitations on general anesthesia coverage which does not result in a fiscal impact to the state or municipalities because carriers do not currently impose these restrictions.

Section 10 regulates fees carriers charge health benefit plans which results in potential savings beginning in FY 27 to the SEHP, SPP, and municipal plans to the extent providers were billing these plans at higher rates than outlined in the bill.

Additionally, the section results in a revenue loss annually beginning in FY 27 to the UConn Health Center (UCHC). It: (1) caps certain reimbursement rates at 150% of the current non-facility Medicare rate; and (2) prohibits facility fees for certain outpatient treatment. The revenue loss resulting from the reimbursement rate cap would vary based on the difference between: (1) UCHC's current reimbursement rates; and (2) 150% of the current non-facility Medicare rate.

The section also prohibits facility fees for certain treatments, regardless of setting, resulting in an additional annual revenue loss to UCHC beginning in FY 27. The revenue loss resulting from this provision will depend on UCHC's current fee structure for such treatments. Currently, the SEHP and SPP incur minimal facility fees.