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sSB-3
AN ACT CONCERNING HEALTH CARE AFFORDABILITY.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 27 $	FY 28 $
Resources of the CAHCT Fund	CAHCT Fund - See Below	See Below	See Below
Resources of the Federal Cuts Response Fund	SF - Transfer from	200 million	None
Resources of the CAHCT Fund	SF - Transfer to	200 million	None
Policy & Mgmt., Off.	GF - Cost	765,200	260,940
Social Services, Dept.	GF - Potential Cost	See Below	See Below
State Comptroller - Fringe Benefits[1]	GF - Cost	108,730	108,730
State Comptroller - Fringe Benefits	Various - Potential Cost	Significant	Significant
UConn Health Ctr.	OF - Potential Revenue Gain	See Below	See Below
Social Services, Dept.	GF - Cost	See Below	See Below

Note: CAHCT Fund = Connecticut Affordable Health Care Trust Fund; SF=Special Fund (Non-appropriated); GF=General Fund; Various=Various

Municipal Impact:

Municipalities	Effect	FY 27 $	FY 28 $
Various Municipalities	Potential Cost	Significant	Significant

Explanation

Sections 1–4 create and fund the Connecticut Affordable Health Care

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 41.82% of payroll in FY 27.

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Trust (CAHCT) fund to, in part, support the design and implementation of a Connecticut Option healthcare program.

Revenues of the CAHCT Fund

Section 3 requires the Office of Policy and Management (OPM) to transfer $200 million from the Federal Cuts Response Fund to the CAHCT Fund in FY 27.

The bill also requires the resources of the CAHCT fund be invested by the Treasurer separate and apart from other state investments, but in the same manner as several other state investment funds. Investment revenues are indeterminate, as they are dependent on available resources, market returns, and future investment decisions.

Expenses of the CAHCT Fund

To the extent amounts on deposit in the fund meets or exceeds the amount needed to fund the program, there will be ongoing annual administrative and investment costs associated with the CAHCT fund as a result of the bill starting no earlier than FY 27. Administrative expenses include a one-time cost to the State Treasurer associated with the establishment of the CAHCT fund of up to $100,000. The bill allows the CAHCT fund to enter into contracts for various administrative, legal, and investment services. The bill specifies the ongoing costs of administering the CAHCT Fund are to be covered by the resources of the fund. As such, there is not anticipated to be a cost to appropriated funds or municipalities due to these sections.

Section 4 establishes a Connecticut Option affordable health care program within OPM. This results in a cost of $500,000 in FY 27 to OPM for a consultant to develop the health care program.

There is also a cost of $132,600 in FY 27 and an annual cost of $130,470 beginning in FY 28 to OPM and corresponding fringe benefit costs beginning in FY 27 to the Office of the State Comptroller for a Policy Development Coordinator position. This position will support an annual reporting requirement in the bill beginning January 1, 2027,

work with the consultant in the design and development of the health care program and serve as the OPM designee for a working group established in section 7 of the bill.

Sections 5 and 6 result in a cost to the Department of Social Services (DSS) associated with establishing a basic health program, which is guided by the recommendations of the working group established in section 7. While the impact of implementing such a program is unknown at this time and dependent on how the program is ultimately structured, DSS will incur initial contracting costs of $750,000 to develop and submit the required waiver as well as costs for additional staff and resources to perform an actuarial analysis, procure a managed care organization, and set up other potentially necessary operational mechanisms to implement the program.

Section 7 establishes a working group within OPM to design the Connecticut Option program established in section 4 of the bill. These requirements outlined in the section contribute to the cost to OPM in section 4 for a Policy Development Coordinator position.

Section 8 requires OPM to hold public hearings and stakeholder engagement meetings. This results in a cost to OPM beginning in FY 27 to hold each of these meetings. This cost is dependent on the number of meetings held and the cost associated with each meeting.

Section 10 results in a potential revenue gain to the UConn Health Center (UCHC) annually beginning in FY 27. It allows any hospital, including UCHC, to participate in a financial assistance program established by the bill for patients who meet certain income and other criteria. Presumably, UCHC would only choose to participate if the program increased net patient revenue, and the bill's reimbursement from DSS offset the cost of participating in this program. Any revenue gain would depend on: (1) the number of qualifying patients who participate; and (2) how the program's changes in qualifying patient payments compare to the reimbursement UCHC would receive from DSS.

In the past 12 months, UConn Health has served at least 5,299 uninsured patients and 749 insured patients who met the bill's income parameters.[2] On average, the uninsured patients who met the bill's income parameters owed $810 out-of-pocket, and they ultimately paid 63% to 72% of that amount (i.e., $227 to $300 is left unpaid). The insured patients owed $301, and they ultimately paid 69% to 81% of that amount (i.e., $57 to $93 left unpaid).

Section 11 results in a Medicaid cost to DSS associated with disproportionate share hospital payments (DSH). The bill requires DSS to make DSH payments to hospitals as compensation for participating in the hospital financial assistance program established by the bill, using criteria to be identified by DSS. The extent of the cost to DSS is unknown and will be based on participating hospitals, criteria developed, and relevant costs. For context, DSH payments must meet federal requirements in order for states to receive a 50% federal share and are subject to both hospital and state specific limits.

Section 12 establishes a safety net mitigation working group within OPM to advise the state's response to significant changes in federal law or policy that impact certain program and requires the group to report annually beginning February 1, 2027. This results in a cost of $132,600 in FY 27 and an annual cost of $130,470 beginning in FY 28 to OPM and corresponding fringe benefit costs beginning in FY 27 to the Office of the State Comptroller for a Policy Development Coordinator position. This position will also be responsible for requirements outlined in section 14 of the bill.

Section 14 requires OPM to notify the certain committees on federal statutes, regulations, rules, or administrative guidance that is likely to impact federal health funding levels and provide recommendations. This results in a cost to OPM for a Policy Development Coordinator

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[2] These numbers represent the number of insured and uninsured patients at UCHC who have applied for financial assistance in the past 12 months and otherwise meet the bill's eligibility parameters. These figures do not include patients who may be eligible to participate in the bill's financial assistance program due to participation in SNAP or WIC.

position that is outlined in section 12.

Section 15 results in a potential cost to DSS to establish a program for collecting information from employers or other entities to support Medicaid and SNAP eligibility determinations. To the extent DSS establishes a program outside of the current scope of practice, DSS may incur system modification costs to support the new program.

Section 17 requires DSS to submit any proposal to change the fee-for-service Medicaid payment model to a managed care payment model to the Appropriations and Human Services committees before implementing or seeking any necessary federal approval to implement such change. To the extent this delays or prevents a change that otherwise would have occurred, the state could experience a fiscal impact that cannot be determined at this time.

Section 18 shortens the timeframe for prior authorization and deems requests approved if health carriers fail to meet these standards. The state and fully insured municipalities may experience significant cost increases in medical and pharmacy spend beginning in FY 27 if the changes outlined in the bill result in greater number of authorizations deemed approved. The state plan currently saves approximately $84 million annually under current prior authorization procedures.

Sections 19 and 20 result in potential increased administrative costs to DSS to the extent participating hospitals utilize the appeals process authorized by the bill as referenced in Section 11.

The bill makes other clarifying, conforming and technical changes that do not result in a fiscal impact.

The Out Years

The annualized ongoing fiscal impact will continue into the future subject to inflation, the allowable scope of DSH payments, and any future changes to the Medicaid payment model.