OLR Bill Analysis

sHB 5041

AN ACT CONCERNING A STUDY OF A CONNECTICUT OPTION FOR AFFORDABLE HEALTH CARE, HEALTH INSURER REQUIREMENTS FOR CERTAIN GENERIC DRUGS, TAX CREDITS FOR SMALL BUSINESS HEALTH CARE ARRANGEMENTS AND WORKER PORTABLE BENEFIT ACCOUNTS.

SUMMARY

This bill requires the Office of Policy and Management (OPM) secretary to study and report on the feasibility of establishing the Connecticut Option program (a standardized, state-designed health benefit plan meant to reduce health care coverage costs that is available to individuals in the state through private or commercial insurers).

The bill also requires, with specified applicability, health benefit plans to make certain generic and biosimilar drugs available on formularies with lower cost sharing relative to the respective reference product already on the formulary. (A "formulary" is a plan's list of covered prescription drugs.)

Next, the bill establishes a tax credit against certain state business taxes for qualified small businesses (those with less than 50 employees) that offer employees an Individual Coverage Health Reimbursement Arrangement (ICHRA). (Established by federal rule in 2019, an ICHRA allows employers to reimburse employees for purchasing individual health coverage (for example, through the individual insurance exchange, Access Health CT).)

The bill also allows for the use of portable benefit accounts, which are accounts eligible workers (for example, independent contractors) use to purchase health insurance generally. It allows a hiring party to withhold a percentage of the eligible worker's compensation for deposit into the account as long as certain conditions are met (for example, prior written consent from the eligible worker for the arrangement).

Lastly, the bill makes changes to the Covered Connecticut program. It removes the Office of Health Strategy's (OHS) involvement in the program, leaving the Department of Social Services (DSS) responsible. It also authorizes DSS to make program changes (for example, to meet federal waiver requirements), and delays the deadline for the program to use only in-network providers to January 1, 2028, subject to federal approval.

EFFECTIVE DATE: Various; see below.

§1 — CONNECTICUT OPTION PROGRAM STUDY

Scope

The bill requires the OPM secretary, within available resources, to study the feasibility of establishing the Connecticut Option program to reduce health insurance premiums. Under the bill, the Connecticut Option program is a standardized, state-designed health benefit plan meant to reduce health care coverage costs and be available to individuals in the state through private or commercial insurers.

The study must include the following:

1. sufficient analyses, conclusions, and recommendations for the OPM secretary to evaluate and compare program design models in consultation with the insurance commissioner;

2. a review of the efficacy, impact, and reasonableness of proposed program design elements (for example, provider reimbursement methodologies, incentives or rewards for high-quality care, and premium assistance or risk stabilization programs);

3. any statutory or regulatory changes, as well as staffing changes across agencies, needed to implement the program;

4. an analysis of the state insurance market and the effect the Connecticut Option program would have on people covered by plans sold through the exchange (Access Health CT); and

5. any state action or design elements needed to achieve premium

savings.

Reporting and Federal Waiver Implementation

The bill requires the OPM secretary to file (1) an interim report on the study with the Appropriations, Human Services, and Insurance and Real Estate committees by January 15, 2027, and (2) a final report that includes findings and recommendations with the same committees by January 31, 2028.

If the secretary, after the study and reporting and in consultation with the insurance commissioner, determines that the Connecticut Option program is feasible, the bill allows him to direct the relevant state agency to develop and implement any applicable federal waivers (for example, those needed to maximize federal funding for the program).

EFFECTIVE DATE: Upon passage

§§ 2 & 3 — FORMULARY REQUIREMENTS FOR GENERIC AND BIOSIMILAR DRUGS

Under the bill, health benefit plans issued or renewed on or after January 1, 2027, must make certain generic and biosimilar drugs available on formularies with lower cost sharing (including out-of-pocket costs) relative to the respective reference product (the comparative brand-name drug or biological product) already on the formulary. If the drug is a biosimilar product, the formulary must include at least one biosimilar product on the formulary in a lower cost sharing tier than the reference product.

The generic or biosimilar drug must:

1. be approved by the U.S. Food and Drug Administration,
2. be marketed based on that approval, and
3. have a lower wholesale acquisition cost on the initial marketing date than the reference product.

Applicability of Requirements

These formulary requirements apply only if the generic or biosimilar

drug has a lower wholesale acquisition cost than the reference product. Furthermore, health benefit plans may not restrict enrollees from using a pharmacy of the enrollee's choice, unless the reference product is similarly restricted.

The bill specifies that it does not require:

1. health benefit plans to cover (a) a reference product after a generic or biosimilar is approved or (b) any drug or product that the formulary developers determine are no longer medically appropriate or cost-effective,

2. health benefit plan coverage or enrollee cost sharing for generic or biosimilar drugs that are not permitted under applicable federal or state laws, or

3. health benefit plans to include on the formulary generic or biosimilar drugs if the formulary developers did not include the reference products due to clinical concerns about their safety or efficacy based on scientific evidence.

The bill's requirements apply only to coverage and cost sharing for generic, biosimilar, and brand-name drugs dispensed by pharmacies as outpatient prescriptions. They do not apply to those provided by a hospital, physician, or other healthcare provider while performing health care services that are paid for by the health benefit plan as part of the payment for medical benefits.

Lastly, the bill specifies that its requirements will not interfere with a pharmacy's or pharmacist's compliance with the state's Pharmacy Practices Act.

Regulations

The bill authorizes the insurance commissioner to adopt implementing regulations.

EFFECTIVE DATE: January 1, 2027

§ 4 — ICHRA TAX CREDIT

The bill establishes an ICHRA tax credit for qualified small businesses. The credit may be claimed against the state insurance and health care center taxes, corporation business tax, or income tax (excluding withholdings generally).

To qualify, a small business (1) cannot employ more than 50 employees in the state when it applies for the tax credit and (2) must have adopted an ICHRA instead of a traditional employer-provided health insurance plan.

Credit Amount

Under the bill, the available credit is the lesser of (1) the sum of qualified contributions made by the qualified small business during the applicable income or taxable year or (2) $1,000 per covered employee. A credit not used during the year it was earned expires and is not refundable. (A "qualified contribution" is the amount the business contributed to an employee's ICHRA during the applicable income or taxable year.)

Credits are available only for two years — the first income or taxable year the business offers the ICHRA and the next one. The bill caps the total amount of tax credits available under the bill at $5 million in any income or taxable year.

For qualified small businesses that are S corporations or partnerships for federal income tax purposes, their shareholders or partners may claim the credit. If the qualified small business is a single member limited liability company (LLC) that is disregarded as an entity separate from its owner, the LLC's owner may claim the credit.

Application

Qualified small businesses must apply to the revenue services commissioner in a manner he sets to reserve an allocation for the credit based upon qualified contributions the business plans to make. The application must show the qualified contributions the business intends to make in each year over the two-year period and anything else the

commissioner deems necessary to administer the credits.

Approval

The bill requires the commissioner to approve applications on a first-come, first-served basis. He must notify the applicant about his decision in writing within 30 days after receiving the application.

Upon approval, the commissioner must issue a certification letter stating the amount of tax credit reserved for the qualified small business for each of the two years. A business may not claim a credit exceeding the amount the commissioner approved.

EFFECTIVE DATE: Upon passage, and applicable to income and taxable years beginning on or after January 1, 2026.

§ 5 — PORTABLE BENEFIT ACCOUNTS

The bill allows a hiring party (someone who hires or contracts with an eligible worker) to contribute to a portable benefits account as a form of compensation for an eligible worker. An "eligible worker" is a person with 1099 tax status (whose compensation is reported on IRS Form 1099; for example, an independent contractor). Portable benefit accounts are administered by providers (banks, investment management firms, or program providers generally) and used by eligible workers to purchase health insurance and for health-related expenses. Making or receiving contributions to a portable benefit account does not determine a person's employment classification.

Under the bill, a hiring party may withhold a percentage of an eligible worker's compensation for deposit in a portable benefits account if the:

1. hiring party and eligible worker agree to it in writing,

2. eligible worker enters the arrangement voluntarily, and

3. written agreement clearly outlines the process to end the arrangement.

The bill allows an eligible worker to opt out of the arrangement at any time by notifying the hiring party in writing. After receiving notice

to terminate the withholding arrangement, a hiring party must return any owed withheld compensation to the eligible worker within 15 days.

EFFECTIVE DATE: October 1, 2026

§ 6 — COVERED CONNECTICUT PROGRAM

By law, the Covered Connecticut program is within DSS and meant to reduce the state's uninsured rate. It generally provides eligible individuals health insurance at no out-of-pocket cost to them. The bill clarifies that the program must provide sufficient premium and cost-sharing subsidies to ensure fully subsidized premium coverage. Under current law, the program must ensure fully subsidized coverage generally.

Department of Social Services Responsibilities

Under the bill, the DSS commissioner must administer the program in consultation with the insurance commissioner. Current law requires consultation with OHS as well.

The bill also allows, instead of requires as under current law, DSS to provide dental and nonemergency medical transportation services to eligible individuals as part of the Covered Connecticut program. DSS may do this on or after January 1, 2027.

Federal Waivers

Under the bill, DSS (instead of OHS as under current law) is responsible for implementing and reporting on the federal waivers that the Covered Connecticut program may use. Correspondingly, the bill makes conforming changes to the waiver implementation process.

Specifically, subject to legislative approval, the bill allows DSS to seek a Section 1332 waiver. If approved by the federal government, DSS must implement the waiver. (A Section 1332 waiver is named after an authorizing section of the federal Affordable Care Act (ACA) and allows a state to waive certain ACA requirements that might otherwise prohibit it from implementing certain programs, such as essential health benefits or marketplace functions.)

After the Covered Connecticut program was first established, DSS submitted a Section 1115 Medicaid demonstration waiver to the Centers for Medicare and Medicaid Services (CMS) to request federal matching funds for the program. CMS subsequently approved the waiver, which is funded by the federal government through December 31, 2027. The bill allows the DSS commissioner to make program design changes needed to meet requirements for approval, renewal, or continuation of the Section 1115 waiver.

Additionally, before the Section 1115 waiver expires, the bill allows the DSS commissioner, in consultation with OPM, to explore, develop, or pursue approval of alternative program designs (including a basic health plan that enables coverage for applicants with household incomes of up to 200% of the federal poverty level).

In-Network Provider Deadline

Under current law, the Covered Connecticut program must include only in-network providers and services, unless the insurance commissioner finds the network inadequate. This took effect October 1, 2024, under PA 24-138. The bill instead requires this by January 1, 2028, subject to federal approval. Available program benefits and cost sharing will only apply if eligible individuals use in-network health care providers and facilities after that date.

EFFECTIVE DATE: Upon passage

BACKGROUND

Related Bills

SB 3, favorably reported by the Human Services Committee, among other things, establishes a Connecticut Option program and a state-run trust fund to finance it, as well as a basic health program as allowed under Section 1331 of the ACA. It also creates a working group to oversee the design of these programs.

sHB 5378 (File 246), favorably reported by the Insurance and Real Estate Committee, requires OPM, in consultation with the insurance commissioner, to study the feasibility of establishing the Connecticut

Option program.

COMMITTEE ACTION

Human Services Committee

Joint Favorable
Yea 16 Nay 7 (03/19/2026)