



General Assembly

February Session, 2004

Raised Bill No. 5530

LCO No. 1948

01948 _____ PH_

Referred to Committee on Public Health

Introduced by:
(PH)

AN ACT CONCERNING RESTORATION OF BENEFITS AND SERVICES UNDER THE MEDICAL ASSISTANCE PROGRAM.

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

1 Section 1. Subsection (b) of section 42 of public act 03-3 of the June
2 30 special session, is repealed and the following is substituted in lieu
3 thereof (*Effective from passage*):

4 (b) [No earlier than September 1, 2003, but not later than October 1,
5 2003] Upon the effective date of this section, the state-administered
6 general assistance program pursuant to this section and any general
7 assistance program operated by a town shall provide cash assistance of
8 (1) [two hundred] three hundred fifty dollars per month to a single
9 unemployable person upon determination of such person's
10 unemployability; (2) two hundred dollars per month for a single
11 transitional individual who is required to pay for shelter; and (3) one
12 hundred fifty dollars per month for a single transitional individual
13 who is not required to pay for shelter. [No earlier than September 1,
14 2003, but not later than October 1, 2003, eligible families shall receive
15 cash assistance in an amount that is fifty dollars less than the standard
16 of assistance such family would receive under the temporary family

17 assistance program.] The standard of assistance paid for individuals
18 residing in rated boarding facilities, shall remain at the level in effect
19 on August 31, 2003. No individual shall be eligible for cash assistance
20 under the program if eligible for cash assistance under any other state
21 or federal cash assistance program.

22 Sec. 2. Section 17b-257 of the general statutes, as amended by section
23 18 of public act 03-2 and section 43 of public act 03-3 of the June 30
24 special session, is repealed and the following is substituted in lieu
25 thereof (*Effective from passage*):

26 [(a) The Commissioner of Social Services shall implement a state
27 medical assistance component of the state-administered general
28 assistance program for persons ineligible for Medicaid. Not later than
29 October 1, 2003, each person eligible for state-administered general
30 assistance shall be entitled to receive medical care through a federally
31 qualified health center or other primary care provider as determined
32 by the commissioner. The Commissioner of Social Services shall
33 determine appropriate service areas and shall, in the commissioner's
34 discretion, contract with community health centers, other similar
35 clinics, and other primary care providers, if necessary, to assure access
36 to primary care services for recipients who live farther than a
37 reasonable distance from a federally qualified health center. The
38 commissioner shall assign and enroll eligible persons in federally
39 qualified health centers and with any other providers contracted for
40 the program because of access needs. Not later than October 1, 2003,
41 each person eligible for state-administered general assistance shall be
42 entitled to receive hospital services. Medical services under the
43 program shall be limited to the services provided by a federally
44 qualified health center, hospital, or other provider contracted for the
45 program at the commissioner's discretion because of access needs. The
46 commissioner shall ensure that ancillary services and specialty services
47 are provided by a federally qualified health center, hospital, or other
48 providers contracted for the program at the commissioner's discretion.
49 Ancillary services include, but are not limited to, radiology, laboratory,

50 and other diagnostic services not available from a recipient's assigned
51 primary-care provider, and durable medical equipment. Specialty
52 services are services provided by a physician with a specialty that are
53 not included in ancillary services. In no event, shall ancillary or
54 specialty services provided under the program exceed such services
55 provided under the state-administered general assistance program on
56 July 1, 2003. Eligibility criteria concerning income shall be the same as
57 the medically needy component of the Medicaid program, except that
58 earned monthly gross income of up to one hundred fifty dollars shall
59 be disregarded. Unearned income shall not be disregarded. No person
60 who has family assets exceeding one thousand dollars shall be eligible.
61 No person eligible for Medicaid shall be eligible to receive medical
62 care through the state-administered general assistance program.

63 (b) Recipients covered by a general assistance program operated by
64 a town shall be assigned and enrolled in federally qualified health
65 centers and with any other providers in the same manner as recipients
66 of medical assistance under the state-administered general assistance
67 program pursuant to subsection (a) of this section.

68 (c) On and after October 1, 2003, pharmacy services shall be
69 provided to recipients of state-administered general assistance through
70 the federally qualified health center to which they are assigned or
71 through a pharmacy with which the health center contracts. Prior to
72 said date, pharmacy services shall be provided as provided under the
73 Medicaid program. Recipients who are assigned to a community
74 health center or similar clinic or primary care provider other than a
75 federally qualified health center or to a federally qualified health
76 center that does not have a contract for pharmacy services shall receive
77 pharmacy services at pharmacies designated by the commissioner.

78 (d) Recipients of state-administered general assistance shall
79 contribute a copayment of one dollar and fifty cents for each
80 prescription.

81 (e) The Commissioner of Social Services shall contract with federally

82 qualified health centers or other primary care providers as necessary to
83 provide medical services to eligible state-administered general
84 assistance recipients pursuant to this section. The commissioner shall,
85 within available appropriations, make payments to such centers based
86 on their pro rata share of the cost of services provided or the number
87 of clients served, or both. The Commissioner of Social Services shall,
88 within available appropriations, make payments to other providers
89 based on a methodology determined by the commissioner. The
90 Commissioner of Social Services may reimburse for extraordinary
91 medical services, provided such services are documented to the
92 satisfaction of the commissioner. For purposes of this section, the
93 commissioner may contract with a managed care organization or other
94 entity to perform administrative functions. Provisions of a contract for
95 medical services entered into by the commissioner pursuant to this
96 section shall supersede any inconsistent provision in the regulations of
97 Connecticut state agencies.

98 (f) Each federally qualified health center participating in the
99 program shall, within thirty days of August 20, 2003, enroll in the
100 federal Office of Pharmacy Affairs Section 340B drug discount
101 program established pursuant to 42 USC 256b to provide pharmacy
102 services to recipients at Federal Supply Schedule costs. Each such
103 health center may establish an on-site pharmacy or contract with a
104 commercial pharmacy to provide such pharmacy services.

105 (g) The Commissioner of Social Services shall, within available
106 appropriations, make payments to hospitals for inpatient services
107 based on their pro rata share of the cost of services provided or the
108 number of clients served, or both. The Commissioner of Social Services
109 shall, within available appropriations, make payments for any
110 ancillary or specialty services provided to state-administered general
111 assistance recipients under this section based on a methodology
112 determined by the commissioner.

113 (h) On or before March 1, 2004, the Commissioner of Social Services

114 shall seek a waiver of federal law under the Health Insurance
115 Flexibility and Accountability demonstration initiative for the purpose
116 of extending health insurance coverage under Medicaid to persons
117 qualifying for medical assistance under the state-administered general
118 assistance program. The provisions of section 17b-8 shall apply to this
119 section.]

120 (a) The Commissioner of Social Services shall implement a state
121 medical assistance program for persons ineligible for Medicaid and on
122 or before April 1, 2004, the commissioner shall implement said
123 program in the towns in which the fourteen regional or district offices
124 of the Department of Social Services are located. The commissioner
125 shall establish a schedule for the transfer of recipients of medical
126 assistance administered by towns under the general assistance
127 program to the state program. To the extent possible, the
128 administration of the state medical assistance program shall parallel
129 that of the Medicaid program as it is administered to recipients of
130 temporary family assistance, including eligibility criteria concerning
131 income and assets. Payment for medical services shall be made only
132 for individuals determined eligible. The rates of payment for medical
133 services shall be those of the Medicaid program. Medical services
134 covered under the program shall be those covered under the Medicaid
135 program, except that long-term care and services available pursuant to
136 a home and community-based services waiver under Section 1915 of
137 the Social Security Act shall not be covered. On and after April 1, 2004,
138 the commissioner shall implement a managed care program for
139 medical services provided under this program, except services
140 provided pursuant to section 17a-453a, as amended. Notwithstanding
141 the provisions of sections 4a-51 and 4a-57, the commissioner may enter
142 into contracts, including, but not limited to, purchase of services
143 agreements to implement the provisions of this section.

144 (b) The commissioner shall implement presumptive and continuous
145 eligibility for a person applying for medical assistance pursuant to this
146 section, unless such person qualifies for Medicaid, exceeds income

147 thresholds or obtains health insurance from another source. Such
148 presumptive eligibility determinations shall be in accordance with
149 applicable federal law and regulations.

150 (c) The Commissioner of Social Services shall make payments to
151 hospitals for any services provided to state-administered general
152 assistance recipients based on the cost of services provided and the
153 number of such recipients served. Said commissioner shall make
154 payments for any ancillary or specialty services provided to such
155 recipients pursuant to this subsection, based on a methodology
156 determined by said commissioner. All payment schedules proposed by
157 said commissioner pursuant to this subsection shall be subject to the
158 approval of the joint standing committees of the General Assembly
159 having cognizance of matters relating to human services and
160 appropriations and budgets of state agencies, and may be denied by
161 either joint standing committee.

162 Sec. 3. Section 17b-261 of the general statutes, as amended by section
163 10 of public act 03-2, section 2 of public act 03-28, section 7 of public act
164 03-268 and section 63 of public act 03-3 of the June 30 special session, is
165 repealed and the following is substituted in lieu thereof (*Effective from*
166 *passage*):

167 (a) Medical assistance shall be provided for any otherwise eligible
168 person whose income, including any available support from legally
169 liable relatives and the income of the person's spouse or dependent
170 child, is not more than one hundred forty-three per cent, pending
171 approval of a federal waiver applied for pursuant to subsection (d) of
172 this section, of the benefit amount paid to a person with no income
173 under the temporary family assistance program in the appropriate
174 region of residence and if such person is an institutionalized
175 individual as defined in Section 1917(c) of the Social Security Act, 42
176 USC 1396p(c), and has not made an assignment or transfer or other
177 disposition of property for less than fair market value for the purpose
178 of establishing eligibility for benefits or assistance under this section.

179 Any such disposition shall be treated in accordance with Section
180 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
181 property made on behalf of an applicant or recipient or the spouse of
182 an applicant or recipient by a guardian, conservator, person
183 authorized to make such disposition pursuant to a power of attorney
184 or other person so authorized by law shall be attributed to such
185 applicant, recipient or spouse. A disposition of property ordered by a
186 court shall be evaluated in accordance with the standards applied to
187 any other such disposition for the purpose of determining eligibility.
188 The commissioner shall establish the standards for eligibility for
189 medical assistance at one hundred forty-three per cent of the benefit
190 amount paid to a family unit of equal size with no income under the
191 temporary family assistance program in the appropriate region of
192 residence, pending federal approval, except that the medical assistance
193 program shall provide coverage to persons under the age of nineteen
194 up to one hundred eighty-five per cent of the federal poverty level
195 without an asset limit. Said medical assistance program shall also
196 provide coverage to persons under the age of nineteen and their
197 parents and needy caretaker relatives who qualify for coverage under
198 Section 1931 of the Social Security Act with family income up to one
199 hundred fifty per cent of the federal poverty level without an asset
200 limit, upon the request of such a person or upon a redetermination of
201 eligibility. Such levels shall be based on the regional differences in
202 such benefit amount, if applicable, unless such levels based on regional
203 differences are not in conformance with federal law. Any income in
204 excess of the applicable amounts shall be applied as may be required
205 by said federal law, and assistance shall be granted for the balance of
206 the cost of authorized medical assistance. All contracts entered into on
207 and after July 1, 1997, pursuant to this section shall include provisions
208 for collaboration of managed care organizations with the Healthy
209 Families Connecticut Program established pursuant to section 17a-56.
210 The Commissioner of Social Services shall provide applicants for
211 assistance under this section, at the time of application, with a written
212 statement advising them of the effect of an assignment or transfer or

213 other disposition of property on eligibility for benefits or assistance.

214 (b) For the purposes of the Medicaid program, the Commissioner of
215 Social Services shall consider parental income and resources as
216 available to a child under eighteen years of age who is living with his
217 or her parents and is blind or disabled for purposes of the Medicaid
218 program, or to any other child under twenty-one years of age who is
219 living with his or her parents.

220 (c) For the purposes of determining eligibility for the Medicaid
221 program, an available asset is one that is actually available to the
222 applicant or one that the applicant has the legal right, authority or
223 power to obtain or to have applied for the applicant's general or
224 medical support. If the terms of a trust provide for the support of an
225 applicant, the refusal of a trustee to make a distribution from the trust
226 does not render the trust an unavailable asset. Notwithstanding the
227 provisions of this subsection, the availability of funds in a trust or
228 similar instrument funded in whole or in part by the applicant or the
229 applicant's spouse shall be determined pursuant to the Omnibus
230 Budget Reconciliation Act of 1993, 42 USC 1396p. The provisions of
231 this subsection shall not apply to special needs trust, as defined in 42
232 USC 1396p(d)(4)(A).

233 (d) The transfer of an asset in exchange for other valuable
234 consideration shall be allowable to the extent the value of the other
235 valuable consideration is equal to or greater than the value of the asset
236 transferred.

237 (e) On or before January 1, 2005, and annually thereafter, the
238 Department of Social Services shall submit a report to the joint
239 standing committee of the General Assembly having cognizance of
240 matters relating to human services, the Children's Health Council and
241 the Medicaid Managed Care Council, in accordance with section 11-4a,
242 which sets forth the following: The number of children receiving
243 Medicaid services; the number of children receiving medical treatment
244 at any state or municipal health care facility; the number of doctors

245 and dentists participating in state or municipally-funded programs;
246 and the percentage of children treated in medical programs whose
247 family income is less than one hundred thirty-three per cent of the
248 federal poverty level and the number of children whose family income
249 is greater than one hundred thirty-three per cent but not more than
250 one hundred eighty-five per cent of the federal poverty level. The
251 report shall be submitted to any member of the General Assembly
252 upon such member's request. A summary of the report shall be
253 submitted to each member of the General Assembly if the summary is
254 two pages or less and a notification of the report shall be submitted to
255 each member if the summary is more than two pages. Submission shall
256 be by mailing the report, summary or notification to the legislative
257 address of each member of the General Assembly.

258 [(e)] (f) The Commissioner of Social Services shall seek a waiver
259 from federal law to permit federal financial participation for Medicaid
260 expenditures for families with incomes of one hundred forty-three per
261 cent of the temporary family assistance program payment standard.

262 [(f) Notwithstanding the provisions of subsection (a) of this section,
263 on or after April 1, 2003, all parent and needy caretaker relatives with
264 incomes exceeding one hundred per cent of the federal poverty level,
265 who are receiving medical assistance pursuant to this section, shall be
266 ineligible for such medical assistance. On and after February 28, 2003,
267 the Department of Social Services shall not accept applications for
268 medical assistance program coverage under Section 1931 of the Social
269 Security Act from parent and needy caretaker relatives with incomes
270 exceeding one hundred per cent of the federal poverty level until on or
271 after July 1, 2005.]

272 (g) To the extent permitted by federal law, Medicaid eligibility shall
273 be extended for two years to a family who becomes ineligible for
274 medical assistance under Section 1931 of the Social Security Act while
275 employed or due to receipt of child support income or a family with an
276 adult who, within six months of becoming ineligible under Section

277 1931 of the Social Security Act becomes employed.

278 [(h) An institutionalized spouse applying for Medicaid and having a
279 spouse living in the community shall be required, to the maximum
280 extent permitted by law, to divert income to such community spouse
281 in order to raise the community spouse's income to the level of the
282 minimum monthly needs allowance, as described in Section 1924 of
283 the Social Security Act. Such diversion of income shall occur before the
284 community spouse is allowed to retain assets in excess of the
285 community spouse protected amount described in Section 1924 of the
286 Social Security Act. The Commissioner of Social Services, pursuant to
287 section 17b-10, may implement the provisions of this subsection while
288 in the process of adopting regulations, provided the commissioner
289 prints notice of intent to adopt the regulations in the Connecticut Law
290 Journal within twenty days of adopting such policy. Such policy shall
291 be valid until the time final regulations are effective.]

292 Sec. 4. Section 17b-292 of the general statutes, as amended by section
293 7 of public act 03-2 and section 56 of public act 03-3 of the June 30
294 special session, is repealed and the following is substituted in lieu
295 thereof (*Effective from passage*):

296 (a) A child who resides in a household with a family income which
297 exceeds one hundred eighty-five per cent of the federal poverty level
298 and does not exceed three hundred per cent of the federal poverty
299 level [may] shall be eligible for subsidized benefits under the HUSKY
300 Plan, Part B. [The services and cost-sharing requirements under the
301 HUSKY Plan, Part B shall be substantially similar to the services and
302 cost-sharing requirements of the largest commercially available health
303 plan offered by a managed care organization, as defined in section 38a-
304 478, offered to residents in this state as measured by the number of
305 covered lives reported to the Department of Insurance in the most
306 recent audited annual report.]

307 (b) A child who resides in a household with a family income over
308 three hundred per cent of the federal poverty level [may] shall be

309 eligible for unsubsidized benefits under the HUSKY Plan, Part B.

310 (c) Whenever a court or family support magistrate orders a
311 noncustodial parent to provide health insurance for a child, such
312 parent may provide for coverage under the HUSKY Plan, Part B.

313 (d) A child who has been determined to be eligible for benefits
314 under either the HUSKY Plan, Part A or Part B, shall remain eligible
315 for said plan for a period of twelve months from such child's
316 determination of eligibility, unless the child attains the age of nineteen
317 years or is no longer a resident of the state.

318 [(d)] (e) To the extent allowed under federal law, the commissioner
319 shall not pay for services or durable medical equipment under the
320 HUSKY Plan, Part B if the enrollee has other insurance coverage for
321 the services or such equipment.

322 [(e)] (f) A newborn child who otherwise meets the eligibility criteria
323 for the HUSKY Plan, Part B shall be eligible for benefits retroactive to
324 his date of birth, provided an application is filed on behalf of the child
325 within thirty days of such date.

326 (g) The commissioner shall implement presumptive eligibility for
327 children applying for Medicaid. Such presumptive eligibility
328 determinations shall be in accordance with applicable federal law and
329 regulations. The commissioner shall adopt regulations, in accordance
330 with the provisions of chapter 54, to establish standards and
331 procedures for the designation of organizations as qualified entities to
332 grant presumptive eligibility. In establishing such regulations, the
333 commissioner shall ensure the representation of state-wide and local
334 organizations that provide services to children of all ages in each
335 region of the state.

336 [(f)] (h) The commissioner shall enter into a contract with an entity
337 to be a single point of entry servicer for applicants and enrollees under
338 the HUSKY Plan, Part A and Part B. The servicer shall jointly market

339 both Part A and Part B together as the HUSKY Plan. Such servicer shall
340 develop and implement public information and outreach activities
341 with community programs. Such servicer shall electronically transmit
342 data with respect to enrollment and disenrollment in the HUSKY Plan,
343 Part B to the commissioner who shall transmit such data to the
344 Children's Health Council.

345 (i) To the extent permitted by federal law, the single point of entry
346 servicer may be one of the entities authorized to grant presumptive
347 eligibility under the HUSKY Plan, Part A.

348 ~~[(g)]~~ (j) The single point of entry servicer shall send an application
349 and supporting documents to the commissioner for determination of
350 eligibility of a child who resides in a household with a family income
351 of one hundred eighty-five per cent or less of the federal poverty level.
352 The servicer shall enroll eligible beneficiaries in the applicant's choice
353 of managed care plan.

354 ~~[(h)]~~ (k) Not more than twelve months after the determination of
355 eligibility for benefits under the HUSKY Plan, Part A and Part B and
356 annually thereafter, the commissioner or the servicer, as the case may
357 be, shall determine if the child continues to be eligible for the plan. The
358 commissioner or the servicer shall mail an application form to each
359 participant in the plan for the purposes of obtaining information to
360 make a determination on eligibility. To the extent permitted by federal
361 law, in determining eligibility for benefits under the HUSKY Plan, Part
362 A and Part B with respect to family income, the commissioner or the
363 servicer shall rely upon information provided in such form by the
364 participant unless the commissioner or the servicer has reason to
365 believe that such information is inaccurate or incomplete. The
366 determination of eligibility shall be coordinated with health plan open
367 enrollment periods.

368 ~~[(i)]~~ (l) The commissioner shall implement the HUSKY Plan, Part B
369 while in the process of adopting necessary policies and procedures in
370 regulation form in accordance with the provisions of section 17b-10.

371 [(j)] (m) The commissioner shall adopt regulations, in accordance
372 with chapter 54, to establish residency requirements and income
373 eligibility for participation in the HUSKY Plan, Part B and procedures
374 for a simplified mail-in application process. Notwithstanding the
375 provisions of section 17b-257b, such regulations shall provide that any
376 child adopted from another country by an individual who is a citizen
377 of the United States and a resident of this state shall be eligible for
378 benefits under the HUSKY Plan, Part B upon arrival in this state.

379 Sec. 5. Section 17b-295 of the general statutes, as amended by section
380 55 of public act 03-3 of the June 30 special session, is repealed and the
381 following is substituted in lieu thereof (*Effective from passage*):

382 (a) The commissioner [shall impose cost-sharing requirements
383 including] may require the payment of a premium or copayment in
384 connection with services provided under the HUSKY Plan, Part B, [to
385 the extent permitted by federal law, and] in accordance with the
386 following limitations:

387 [(1) On and after October 1, 2003, the commissioner may increase
388 the maximum annual aggregate cost-sharing requirements provided
389 that such cost-sharing requirements shall not exceed five per cent of
390 the family's gross annual income. The commissioner may impose a
391 premium requirement on families, whose income exceeds one hundred
392 eighty-five per cent of the federal poverty level as a component of the
393 family's cost-sharing responsibility provided the family's annual
394 combined premiums and copayments do not exceed the maximum
395 annual aggregate cost-sharing requirement; and]

396 (1) On and after the effective date of this section, the commissioner
397 shall submit a schedule for the maximum annual aggregate cost
398 sharing for families with an income (A) which exceeds one hundred
399 eighty-five per cent of the federal poverty level but does not exceed
400 two hundred thirty-five per cent of the federal poverty level, and (B)
401 which exceeds two hundred thirty-five per cent of the federal poverty
402 level but does not exceed three hundred per cent of the federal poverty

403 level, to the joint standing committee of the General Assembly having
404 cognizance of matters relating to human services. Within fifteen days
405 of receipt of such schedule, said joint standing committee of the
406 General Assembly may advise the commissioner of its' approval,
407 denial or modifications, if any, of the schedule; and

408 (2) The commissioner shall require each managed care plan to
409 monitor copayments and premiums under the provisions of
410 subdivision (1) of this subsection.

411 (b) (1) Except as provided in subdivision (2) of this subsection, the
412 commissioner may [impose limitations on the amount, duration and
413 scope of benefits under the HUSKY Plan, Part B] not impose
414 limitations on the amount, duration and scope of benefits under the
415 HUSKY Plan, Part B, which are medically necessary, unless such
416 limitations are approved in advance by the joint standing committee of
417 the General Assembly having cognizance of matters relating to human
418 services.

419 (2) The limitations adopted by the commissioner pursuant to
420 subdivision (1) of this subsection shall not preclude coverage of any
421 item of durable medical equipment or service that is medically
422 necessary.

423 Sec. 6. Subsection (c) of section 17b-297 of the general statutes, as
424 amended by section 57 of public act 03-3 of the June 30 special session,
425 is repealed and the following is substituted in lieu thereof (*Effective*
426 *from passage*):

427 (c) The commissioner shall, within available appropriations,
428 contract with qualified entities authorized to grant presumptive
429 eligibility, severe need schools and community-based organizations for
430 purposes of public education, outreach and recruitment of eligible
431 children, including the distribution of applications and information
432 regarding enrollment in the HUSKY Plan, Part A and Part B. In
433 awarding such contracts, the commissioner shall consider the

434 marketing, outreach and recruitment efforts of organizations. For the
435 purposes of this subsection, (1) "community-based organizations" shall
436 include, but not be limited to, day care centers, schools, school-based
437 health clinics, community-based diagnostic and treatment centers and
438 hospitals, and (2) "severe need school" means a school in which forty
439 per cent or more of the lunches served are served to students who are
440 eligible for free or reduced price lunches.

441 Sec. 7. Section 17b-290 of the general statutes, as amended by section
442 73 of public act 03-3 of the June 30 special session, is repealed and the
443 following is substituted in lieu thereof (*Effective from passage*):

444 As used in sections 17b-289 to 17b-303, inclusive, [section 72 of
445 public act 03-3 of the June 30 special session,] and section 16 of public
446 act 97-1 of the October 29 special session*:

447 (1) "Applicant" means an individual over the age of eighteen years
448 who is a natural or adoptive parent or a legal guardian; a caretaker
449 relative, foster parent or stepparent with whom the child resides; or a
450 noncustodial parent under order of a court or family support
451 magistrate to provide health insurance, who applies for coverage
452 under the HUSKY Plan, Part B on behalf of a child and shall include a
453 child who is eighteen years of age or emancipated in accordance with
454 the provisions of sections 46b-150 to 46b-150e, inclusive, and who is
455 applying on his own behalf or on behalf of a minor dependent for
456 coverage under such plan;

457 (2) "Child" means an individual under nineteen years of age;

458 (3) "Coinsurance" means the sharing of health care expenses by the
459 insured and an insurer in a specified ratio;

460 (4) "Commissioner" means the Commissioner of Social Services;

461 (5) "Copayment" means a payment made on behalf of an enrollee for
462 a specified service under the HUSKY Plan, Part B;

463 (6) "Cost sharing" means arrangements made on behalf of an
464 enrollee whereby an applicant pays a portion of the cost of health
465 services, sharing costs with the state and includes copayments,
466 premiums, deductibles and coinsurance;

467 (7) "Deductible" means the amount of out-of-pocket expenses that
468 would be paid for health services on behalf of an enrollee before
469 becoming payable by the insurer;

470 (8) "Department" means the Department of Social Services;

471 (9) "Durable medical equipment" means durable medical
472 equipment, as defined in Section 1395x(n) of the Social Security Act;

473 (10) "Eligible beneficiary" means a child who meets the
474 requirements specified in section 17b-292, as amended by this act,
475 except a child excluded under the provisions of Subtitle J of Public
476 Law 105-33 or a child of any municipal employee eligible for
477 employer-sponsored insurance on or after October 30, 1997, provided a
478 child of such a municipal employee may be eligible for coverage under
479 the HUSKY Plan, Part B if dependent coverage was terminated due to
480 an extreme economic hardship on the part of the employee, as
481 determined by the commissioner;

482 (11) "Enrollee" means an eligible beneficiary who receives services
483 from a managed care plan under the HUSKY Plan, Part B;

484 (12) "Family" means any combination of the following: (A) An
485 individual; (B) the individual's spouse or coparent; (C) any child of the
486 individual or such spouse or coparent; or (D) the legal guardian of any
487 such child if the guardian resides with the child. For purposes of this
488 subdivision, "coparent" means a person who shares parental
489 responsibility for the child;

490 (13) "HUSKY Plan, Part A" means assistance provided to children
491 pursuant to section 17b-261, as amended by this act;

492 (14) "HUSKY Plan, Part B" means the health insurance plan for
493 children established pursuant to the provisions of sections 17b-289 to
494 17b-303, inclusive, and section 16 of public act 97-1 of the October 29
495 special session*;

496 (15) "HUSKY Plus programs" means two supplemental health
497 insurance programs established pursuant to section 17b-294 for
498 medically eligible enrollees of the HUSKY Plan, Part B whose medical
499 needs cannot be accommodated within the basic benefit package
500 offered to enrollees. One program shall supplement coverage for those
501 medically eligible enrollees with intensive physical health needs and
502 the other program shall supplement coverage for those medically
503 eligible enrollees with intensive behavioral health needs;

504 (16) "Income" means income as calculated in the same manner as
505 under the Medicaid program pursuant to section 17b-261, as amended
506 by this act;

507 (17) "Managed care plan" means a plan offered by an entity that
508 contracts with the department to provide benefits to enrollees on a
509 prepaid basis;

510 (18) "Parent" means a natural parent, stepparent, adoptive parent,
511 guardian or custodian of a child;

512 (19) "Premium" means any required payment made by an
513 individual to offset or pay in full the capitation rate under the HUSKY
514 Plan, Part B;

515 (20) "Preventive care and services" means: (A) Child preventive
516 care, including periodic and interperiodic well-child visits, routine
517 immunizations, health screenings and routine laboratory tests; (B)
518 prenatal care, including care of all complications of pregnancy; (C) care
519 of newborn infants, including attendance at high-risk deliveries and
520 normal newborn care; (D) WIC evaluations; (E) child abuse assessment
521 required under sections 17a-106a and 46b-129a; (F) preventive dental

522 care for children; and (G) periodicity schedules and reporting based on
523 the standards specified by the American Academy of Pediatrics;

524 (21) "Primary and preventive health care services" means the
525 services of licensed physicians, optometrists, nurses, nurse
526 practitioners, midwives and other related health care professionals
527 which are provided on an outpatient basis, including routine well-
528 child visits, diagnosis and treatment of illness and injury, laboratory
529 tests, diagnostic x-rays, prescription drugs, radiation therapy,
530 chemotherapy, hemodialysis, emergency room services, and outpatient
531 alcohol and substance abuse services, as defined by the commissioner;

532 (22) "Qualified entity" means any entity: (A) Eligible for payments
533 under a state plan approved under Medicaid and which provides
534 medical services under the HUSKY Plan, Part A, or (B) that is a
535 qualified entity, as defined in 42 USC 1396r-1a, as amended by Section
536 708 of Public Law 106-554 and that is determined by the commissioner
537 to be capable of making the determination of eligibility. The
538 commissioner shall provide qualified entities with such forms as are
539 necessary for an application to be made on behalf of a child under the
540 HUSKY Plan, Part A and information on how to assist parents,
541 guardians and other persons in completing and filing such forms;

542 (23) "WIC" means the federal Special Supplemental Food Program
543 for Women, Infants and Children administered by the Department of
544 Public Health pursuant to section 19a-59c.

545 Sec. 8. (*Effective from passage*) The sum of one hundred thousand
546 dollars is appropriated to the Department of Social Services, from the
547 General Fund, for the fiscal year ending June 30, 2004, for services to
548 the elderly.

549 Sec. 9. (*Effective from passage*) The sum of seven hundred fifty
550 thousand dollars is appropriated to the Department of Social Services,
551 from the General Fund, for the fiscal year ending June 30, 2004, for the
552 Children's Health Council.

553 Sec. 10. (*Effective from passage*) Sections 69 and 72 of public act 03-3
554 of the June 30 special session and section 11 of public act 03-1 of the
555 September 8 special session are repealed.

This act shall take effect as follows:	
Section 1	<i>from passage</i>
Sec. 2	<i>from passage</i>
Sec. 3	<i>from passage</i>
Sec. 4	<i>from passage</i>
Sec. 5	<i>from passage</i>
Sec. 6	<i>from passage</i>
Sec. 7	<i>from passage</i>
Sec. 8	<i>from passage</i>
Sec. 9	<i>from passage</i>
Sec. 10	<i>from passage</i>

Statement of Purpose:

To restore benefits and services under the state medical assistance program and to supplement services to the elderly.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]