



General Assembly

**Substitute Bill No. 5534**

February Session, 2004

\*            HB05534APP            042004            \*

**AN ACT CONCERNING MEDICAID FOR THE EMPLOYED DISABLED  
AND HEALTH INSURANCE FOR LOW INCOME ADULTS.**

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

1       Section 1. Subsection (b) of section 17b-597 of the general statutes is  
2       repealed and the following is substituted in lieu thereof (*Effective*  
3       *October 1, 2004*):

4       (b) The Commissioner of Social Services shall amend the Medicaid  
5       state plan to allow persons specified in subsection (a) of this section to  
6       qualify for medical assistance. The amendment shall include the  
7       following requirements: (1) That the person be engaged in a  
8       substantial and reasonable work effort as determined by the  
9       commissioner and as permitted by federal law and have an annual  
10      adjusted gross income, as defined in Section 62 of the Internal Revenue  
11      Code of 1986, or any subsequent corresponding internal revenue code  
12      of the United States, as amended from time to time, of no more than  
13      seventy-five thousand dollars per year; (2) a disregard of all countable  
14      income up to two hundred per cent of the federal poverty level; (3) for  
15      an unmarried person, an asset limit of ten thousand dollars, and for a  
16      married couple, an asset limit of fifteen thousand dollars; (4) a  
17      disregard of any retirement and medical savings accounts established  
18      pursuant to 26 USC 220 and held by either the person or the person's  
19      spouse; (5) a disregard of any moneys in accounts designated by the

20 person or the person's spouse for the purpose of purchasing goods or  
21 services that will increase the employability of such person, subject to  
22 approval by the commissioner; (6) a disregard of spousal income solely  
23 for purposes of determination of eligibility; and (7) a contribution of  
24 any countable income of the person or the person's spouse which  
25 exceeds two hundred per cent of the federal poverty level, as adjusted  
26 for the appropriate family size, equal to ten per cent of the excess  
27 minus any premiums paid from income for health insurance by any  
28 family member, but which does not exceed the lower of seven and one-  
29 half per cent of the adjusted gross family income or the maximum  
30 contribution allowable under Section 201(a)(3) of Public Law 106-170,  
31 as amended from time to time.

32 Sec. 2. (NEW) (*Effective October 1, 2004*) (a) As used in sections 2 to 4,  
33 inclusive, of this act:

34 (1) "Administrative services fee" means any required payment made  
35 by an individual for the purpose of defraying the administrative costs  
36 of the plan;

37 (2) "Capitation" means a payment system in which enrollees pay a  
38 fixed monthly fee to a managed care organization in return for the  
39 provision of a specific range of services for a contract year;

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

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

43 (5) "Copayment" means a payment made on behalf of an enrollee for  
44 a specified service under the plan;

45 (6) "Department" means the Department of Social Services;

46 (7) "Eligible business" means a small employer, as defined in section  
47 38a-564 of the general statutes, and includes, but is not limited to, a  
48 municipality that has fifty or fewer employees;

49 (8) "Eligible individual" means a person who is nineteen years of age  
50 or older, has an income that exceeds one hundred per cent of the  
51 federal poverty level when income is calculated as provided in section  
52 17b-261 of the general statutes, as amended, and: (A) A self-employed  
53 individual (i) who works and resides in the state, (ii) who is organized  
54 as a sole proprietorship or in any other legally recognized manner, and  
55 (iii) whose primary source of income derives from a trade or business  
56 through which the individual has attempted to earn taxable income;  
57 (B) An unemployed individual who resides in this state; or (C) an  
58 individual employed in an eligible business that does not offer health  
59 insurance;

60 (9) "Enrollee" means an eligible individual who receives services  
61 from a managed care organization under the plan;

62 (10) "Plan" means the affordable health insurance plan established  
63 pursuant to sections 2 to 4, inclusive, of this act;

64 (11) "Managed care organization" means an entity that contracts  
65 with the department to offer a plan providing benefits to enrollees on a  
66 prepaid basis; and

67 (12) "Premium" means any required payment made by an enrollee  
68 to pay in full the capitation rate under the plan.

69 (b) The commissioner shall establish an affordable health insurance  
70 plan that shall, after start-up costs, be paid for by the enrollees, except  
71 as provided in subsection (d) of this section, through premiums and  
72 administrative services fees. An eligible individual may apply for  
73 enrollment in such plan if such individual (1) was uninsured as of  
74 January 1, 2004, or is employed by an eligible business, and (2) is  
75 uninsured on the date of the application for enrollment.

76 (c) Except as provided in subsection (d) of this section, an applicant  
77 for enrollment in the plan shall, at the time of application, be required  
78 to pay a fifty-dollar application fee to the department. An enrollee  
79 shall, annually, upon reenrollment, pay a fifty-dollar enrollment fee

80 and an administrative services fee to the department in accordance  
81 with the provisions of subsection (h) of this section.

82 (d) An eligible business may pay, on behalf of an employee, any fees  
83 or premiums charged to such employee who has enrolled in the  
84 affordable health insurance plan.

85 (e) (1) The commissioner shall enter into a contract with an entity to  
86 be a single point of entry servicer for applicants and enrollees under  
87 the plan. The servicer shall enroll eligible beneficiaries in such  
88 beneficiary's choice of managed care organization. Such servicer shall  
89 electronically transmit data with respect to enrollment and  
90 disenrollment in the plan to the commissioner.

91 (2) The commissioner or, at the commissioner's discretion, the single  
92 point of entry servicer shall review applications for eligibility to  
93 determine whether applicants or employers of applicants have  
94 discontinued employer-sponsored coverage for the purpose of  
95 participation in the plan.

96 (3) An application may be disapproved if it is determined that an  
97 applicant was covered by an employer-sponsored insurance within  
98 four months prior to the date of application. If the commissioner  
99 determines that the time period specified in this subsection is  
100 insufficient to effectively deter applicants or employers of applicants  
101 from discontinuing employer-sponsored coverage for the purpose of  
102 participation in the plan, the commissioner may extend such period for  
103 a maximum of an additional two months.

104 (4) An application may be approved in cases where prior employer-  
105 sponsored coverage ended less than four months prior to the date of  
106 application, for reasons unrelated to the availability of the plan,  
107 including, but not limited to:

108 (A) Loss of employment due to factors other than voluntary  
109 termination;

110 (B) Change to a new employer that does not provide an option for  
111 health benefits;

112 (C) Change of address so that no employer-sponsored coverage is  
113 available;

114 (D) Discontinuation of health benefits to all employees of the  
115 applicant's employer;

116 (E) Expiration of the coverage periods established by the  
117 Consolidated Omnibus Budget Reconciliation Act of 1985, (P.L. 99-272)  
118 as amended from time to time, (COBRA);

119 (F) Self-employment;

120 (G) Termination of health benefits due to a long-term disability;

121 (H) Termination of health benefits due to an extreme economic  
122 hardship on the part of either the employee or the employer, as  
123 determined by the commissioner; or

124 (I) Substantial reduction in either lifetime medical benefits or benefit  
125 category available to an employee under an employer's health care  
126 plan.

127 (f) The plan shall provide all benefits mandated by state or federal  
128 law. The commissioner may apply an exclusion for preexisting  
129 conditions, as permitted by federal or state law. The commissioner  
130 may impose lifetime or annual benefit maximums and limitations on  
131 the amount, duration and scope of benefits under the plan, and may  
132 establish a schedule of copayments and coinsurance for coverage  
133 provided under the plan.

134 (g) The commissioner shall require the payment of a premium in  
135 connection with services provided under the plan in accordance with  
136 the following limitations: (1) On or before September 1, 2005, and  
137 annually thereafter, the commissioner shall establish a schedule for the  
138 maximum aggregate premium for individuals enrolling in the plan,

139 and (2) the commissioner shall require each managed care  
140 organization to monitor premiums under the provisions of this section.

141 (h) (1) The administrative services fee shall be sufficient to cover the  
142 administrative costs of the plan and the publicity costs incurred  
143 pursuant to section 4 of this act. On or before August 15, 2004, and  
144 prior to the establishment of premium schedules for enrollees in the  
145 plan program for the first year, the commissioner shall calculate (A)  
146 administrative costs to be incurred by the department in the  
147 implementation and development of the plan, (B) the anticipated  
148 administrative costs for routine operation of the plan for the first year,  
149 and (C) an amount to be used to reimburse the General Fund for the  
150 first year for the start-up costs of the affordable health insurance plan  
151 administrative costs account established pursuant to section 3 of this  
152 act. On or before August 15, 2005, and annually thereafter, the  
153 commissioner shall calculate the anticipated administrative costs for  
154 routine operation of the plan for the year and an amount to be used to  
155 reimburse the General Fund for the year for the start-up costs of said  
156 account established pursuant to section 3 of this act.

157 (2) Administrative costs calculated by the commissioner pursuant to  
158 subdivision (1) of this section shall be paid for by moneys deposited in  
159 said account established pursuant to section 3 of this act.

160 (i) (1) On or before September 1, 2004, the commissioner shall enter  
161 into contracts with managed care organizations to provide the services  
162 described in subsection (f) of this section to enrollees in the plan. Such  
163 contracts shall require the establishment of an internal quality  
164 assurance plan by each managed care organization which shall be in  
165 writing and available to the public.

166 (2) Each managed care organization shall include sufficient numbers  
167 of appropriately trained and certified clinicians, including primary,  
168 medical subspecialty and surgical specialty physicians, as well as  
169 providers of necessary related services to assure enrollees the option of  
170 obtaining benefits through such providers.

171 (3) Each managed care organization that enters into a contract with  
172 the department pursuant to subdivision (1) of this subsection to  
173 provide comprehensive services under the plan, shall have primary  
174 responsibility for ensuring that its behavioral health and dental  
175 subcontractors adhere to the contract between the department and the  
176 managed care organization, including the provision of timely  
177 payments to providers and interest payments in accordance with  
178 subdivision (15) of section 38a-816 of the general statutes, as amended.  
179 The managed care organization shall submit to the department a  
180 claims aging inventory report including all data on all services paid by  
181 subcontractors in accordance with the terms of the contract with the  
182 department.

183 (4) Upon the initial contract or the renewal of a contract between a  
184 managed care organization and a behavioral health or dental  
185 subcontractor, the department shall require that the managed care  
186 organizations impose a performance bond, letter of credit, statement of  
187 financial reserves or payment withhold for behavioral health and  
188 dental subcontractors that provide services under the plan. Any such  
189 performance bond, letter of credit, statement of financial reserves or  
190 payment withhold that may be required by the department pursuant  
191 to a contract with a managed care organization shall be in an amount  
192 sufficient to assure the settlement of provider claims in the event that  
193 the contract between the managed care organization and the  
194 behavioral health or dental subcontractor is terminated. Upon the  
195 initial contract or the renewal of a contract between a managed care  
196 organization and a behavioral health or dental subcontractor, the  
197 managed care organization shall negotiate and enter into a contract  
198 termination agreement with its behavioral health and dental  
199 subcontractors that shall include, but not be limited to, provisions  
200 concerning financial responsibility for the final settlement of provider  
201 claims and data reporting to the department. The managed care  
202 organization shall submit reports to the department, at such times as  
203 the department shall determine, concerning any payments made from  
204 such performance bond or any payment withholds, the timeliness of

205 claim payments to providers and the payment of any interest to  
206 providers.

207 (j) (1) The commissioner shall contract for the external quality  
208 review of the plan. Such review shall include, but need not be limited  
209 to, an evaluation of access to care, medical record standards, provider  
210 credentialing and individual case review.

211 (2) The commissioner may impose the following sanctions on any  
212 managed care organization which does not meet the quality of care  
213 required by regulations adopted pursuant to subsection (l) of this  
214 section or the standards developed for external quality review by a  
215 contract under the provisions of subdivision (1) of this subsection:

216 (A) Require the managed care organization to submit and  
217 implement a plan of correction;

218 (B) Limit new enrollment during any period of noncompliance;

219 (C) Withhold state payments that may become due until the  
220 deficiencies are corrected; or

221 (D) Prohibit the managed care organization from renewing or  
222 entering into new contracts to serve enrollees.

223 (k) Any payment made by the state on behalf of an enrollee as a  
224 result of any false statement, misrepresentation or concealment of or  
225 failure to disclose income or health insurance coverage by an applicant  
226 may be recovered by the state.

227 (l) (1) The commissioner shall adopt regulations, in accordance with  
228 chapter 54 of the general statutes, necessary to implement the  
229 provisions of this section, including, but not limited to, the  
230 establishment of residency requirements, methods for determining  
231 income eligibility for participation in the plan, procedures for a  
232 simplified mail-in application process, appropriate contract standards  
233 to oversee and ensure the quality of care provided by managed care  
234 organizations under the plan, and criteria for assessing the outcomes

235 of health care provided to enrollees in the plan.

236 (2) The commissioner shall implement the policies and procedures  
237 necessary to carry out the provisions of this section, while in the  
238 process of adopting such policies and procedures in regulation form,  
239 provided notice of intent to adopt the regulations is published in the  
240 Connecticut Law Journal no later than twenty days after  
241 implementation. Such policies and procedures shall be valid until the  
242 time final regulations are effective.

243 (m) On or before January 1, 2005, and annually thereafter, the  
244 commissioner shall submit a report, in accordance with the provisions  
245 of section 11-4a of the general statutes, to the joint standing committees  
246 of the General Assembly having cognizance of matters relating to  
247 public health and insurance regarding the establishment and operation  
248 of the plan established by this section.

249 Sec. 3. (NEW) (*Effective from passage*) (a) There is established, within  
250 the General Fund, a separate, nonlapsing account to be known as the  
251 "affordable health insurance plan administrative costs account".  
252 Moneys received by the Department of Social Services pursuant to  
253 subsection (c) of section 2 of this act shall be deposited in the account.  
254 The account shall also contain any funds received pursuant to  
255 subsection (c) of this section. Investment earnings credited to the assets  
256 of the account shall become part of the assets of the account. Any  
257 balance remaining in the account at the end of any fiscal year shall be  
258 carried forward for the fiscal year next succeeding. The moneys in said  
259 account shall be used to pay for administrative costs incurred by the  
260 department through the development, implementation and routine  
261 operation of the plan and to reimburse the General Fund in accordance  
262 with subsection (b) of this section.

263 (b) On or before July 1, 2005, and annually thereafter, the  
264 Commissioner of Social Services, in accordance with the provisions of  
265 subsection (h) of section 2 of this act, shall allocate a percentage of  
266 administrative fees to reimburse the General Fund for the start-up

267 costs for the plan.

268 (c) The Commissioner of Social Services, subject to any limitations  
 269 otherwise imposed by law, may receive and accept on behalf of the  
 270 state for deposit in the account, any funds which may be offered or  
 271 which may become available from federal grants or appropriation,  
 272 private gifts, donations or bequests, or from any other source, for  
 273 purposes of section 2 of this act.

274 Sec. 4. (NEW) (*Effective from passage*) (a) The Commissioner of Social  
 275 Services, in consultation with the Labor Commissioner and the  
 276 Commissioners of Economic and Community Development and Public  
 277 Health, shall develop mechanisms for outreach for the affordable  
 278 health insurance plan established pursuant to section 2 of this act,  
 279 including, but not limited to, publicizing the availability of such plan,  
 280 the eligibility criteria and how to apply for enrollment, development of  
 281 mail-in applications and appropriate outreach materials through the  
 282 Departments of Revenue Services, Social Services, Economic and  
 283 Community Development and Public Health and the Labor  
 284 Department.

285 (b) All such outreach materials shall be approved by the  
 286 Commissioner of Social Services.

287 Sec. 5. (*Effective from passage*) The sum of one hundred thousand  
 288 dollars is appropriated to the Department of Social Services, from the  
 289 General Fund, for the fiscal year ending June 30, 2005, for deposit in  
 290 the affordable health insurance plan administrative costs account  
 291 established pursuant to section 3 of this act.

This act shall take effect as follows:	
Section 1	<i>October 1, 2004</i>
Sec. 2	<i>October 1, 2004</i>
Sec. 3	<i>from passage</i>
Sec. 4	<i>from passage</i>
Sec. 5	<i>from passage</i>

**PH**      *Joint Favorable Subst.*

**APP**     *Joint Favorable*