



General Assembly

February Session, 2004

**Raised Bill No. 5615**

LCO No. 2038

\* \_\_\_\_\_ HB05615HS\_APP031604 \_\_\_\_\_ \*

Referred to Committee on Human Services

Introduced by:  
(HS)

**AN ACT CONCERNING REVISIONS TO THE HUSKY PROGRAM.**

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

1 Section 1. (NEW) (*Effective from passage*) (a) As used in this section:

2 (1) "Employer" means a person, firm or corporation, engaged in  
3 business who has one or more employees, including the state and any  
4 political subdivision of the state; and

5 (2) "State funds" means any bond revenues or money appropriated  
6 or allocated by the General Assembly.

7 (b) The state and any employer that (1) receives state funds, and (2)  
8 has employees who are required to pay premiums in order to receive  
9 benefits under the HUSKY Plan, Part B, as defined in section 17b-290  
10 of the general statutes, as amended by this act, shall, with the consent  
11 of an employee who exercises such option, provide for the collection of  
12 HUSKY premiums pursuant to section 17b-295 of the general statutes,  
13 as amended by this act, through payroll deductions.

14 Sec. 2. Section 17b-290 of the general statutes, as amended by section  
15 73 of public act 03-3 of the June 30 special session, is repealed and the

16 following is substituted in lieu thereof (*Effective from passage*):

17 As used in sections 17b-289 to 17b-303, inclusive, [section 72 of this  
18 act,] and section 16 of public act 97-1 of the October 29 special session\*:

19 (1) "Applicant" means an individual over the age of eighteen years  
20 who is a natural or adoptive parent or a legal guardian; a caretaker  
21 relative, foster parent or stepparent with whom the child resides; or a  
22 noncustodial parent under order of a court or family support  
23 magistrate to provide health insurance, who applies for coverage  
24 under the HUSKY Plan, Part B on behalf of a child and shall include a  
25 child who is eighteen years of age or emancipated in accordance with  
26 the provisions of sections 46b-150 to 46b-150e, inclusive, and who is  
27 applying on his own behalf or on behalf of a minor dependent for  
28 coverage under such plan;

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

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

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

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

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

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

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

43 (9) "Durable medical equipment" means durable medical

44 equipment, as defined in Section 1395x(n) of the Social Security Act;

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

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

56 (12) "Family" means any combination of the following: (A) An  
57 individual; (B) the individual's spouse; (C) any child of the individual  
58 or such spouse; or (D) the legal guardian of any such child if the  
59 guardian resides with the child;

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

62 (14) "HUSKY Plan, Part B" means the health insurance plan for  
63 children established pursuant to the provisions of sections 17b-289 to  
64 17b-303, inclusive, and section 16 of public act 97-1 of the October 29  
65 special session\*;

66 (15) "HUSKY Plus programs" means two supplemental health  
67 insurance programs established pursuant to section 17b-294 for  
68 medically eligible enrollees of the HUSKY Plan, Part B whose medical  
69 needs cannot be accommodated within the basic benefit package  
70 offered to enrollees. One program shall supplement coverage for those  
71 medically eligible enrollees with intensive physical health needs and  
72 the other program shall supplement coverage for those medically  
73 eligible enrollees with intensive behavioral health needs;

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

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

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

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

85 (20) "Preventive care and services" means: (A) Child preventive  
86 care, including periodic and interperiodic well-child visits, routine  
87 immunizations, health screenings and routine laboratory tests; (B)  
88 prenatal care, including care of all complications of pregnancy; (C) care  
89 of newborn infants, including attendance at high-risk deliveries and  
90 normal newborn care; (D) WIC evaluations; (E) child abuse assessment  
91 required under sections 17a-106a and 46b-129a; (F) preventive dental  
92 care for children; and (G) periodicity schedules and reporting based on  
93 the standards specified by the American Academy of Pediatrics;

94 (21) "Primary and preventive health care services" means the  
95 services of licensed physicians, optometrists, nurses, nurse  
96 practitioners, midwives and other related health care professionals  
97 which are provided on an outpatient basis, including routine well-  
98 child visits, diagnosis and treatment of illness and injury, laboratory  
99 tests, diagnostic x-rays, prescription drugs, radiation therapy,  
100 chemotherapy, hemodialysis, emergency room services, and outpatient  
101 alcohol and substance abuse services, as defined by the commissioner;

102 (22) "Qualified entity" means any entity: (A) Eligible for payments  
103 under a state plan approved under Medicaid and which provides

104 medical services under the HUSKY Plan, Part A, or (B) that is a  
105 qualified entity, as defined in 42 USC 1396r-1a, as amended by Section  
106 708 of Public Law 106-554 and that is determined by the commissioner  
107 to be capable of making the determination of eligibility. The  
108 commissioner shall provide qualified entities with such forms as are  
109 necessary for an application to be made on behalf of a child under the  
110 HUSKY Plan, Part A and information on how to assist parents,  
111 guardians and other persons in completing and filing such forms;

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

115 Sec. 3. Section 17b-292 of the general statutes, as amended by section  
116 7 of public act 03-2 and section 56 of public act 03-3 of the June 30  
117 special session, is repealed and the following is substituted in lieu  
118 thereof (*Effective from passage*):

119 (a) A child who resides in a household with a family income which  
120 exceeds one hundred eighty-five per cent of the federal poverty level  
121 and does not exceed three hundred per cent of the federal poverty  
122 level may be eligible for subsidized benefits under the HUSKY Plan,  
123 Part B. [The services and cost-sharing requirements under the HUSKY  
124 Plan, Part B shall be substantially similar to the services and cost-  
125 sharing requirements of the largest commercially available health plan  
126 offered by a managed care organization, as defined in section 38a-478,  
127 offered to residents in this state as measured by the number of covered  
128 lives reported to the Department of Insurance in the most recent  
129 audited annual report.]

130 (b) A child who resides in a household with a family income over  
131 three hundred per cent of the federal poverty level may be eligible for  
132 unsubsidized benefits under the HUSKY Plan, Part B.

133 (c) Whenever a court or family support magistrate orders a  
134 noncustodial parent to provide health insurance for a child, such

135 parent may provide for coverage under the HUSKY Plan, Part B.

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

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

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

149 (g) The commissioner shall implement presumptive eligibility for  
150 children applying for Medicaid. Such presumptive eligibility  
151 determinations shall be in accordance with applicable federal law and  
152 regulations. The commissioner shall adopt regulations, in accordance  
153 with chapter 54, to establish standards and procedures for the  
154 designation of organizations as qualified entities to grant presumptive  
155 eligibility. In establishing such regulations, the commissioner shall  
156 ensure the representation of state-wide and local organizations that  
157 provide services to children of all ages in each region of the state.

158 ~~[(f)]~~ (h) The commissioner shall enter into a contract with an entity  
159 to be a single point of entry servicer for applicants and enrollees under  
160 the HUSKY Plan, Part A and Part B. The servicer shall jointly market  
161 both Part A and Part B together as the HUSKY Plan. Such servicer shall  
162 develop and implement public information and outreach activities  
163 with community programs. Such servicer shall electronically transmit  
164 data with respect to enrollment and disenrollment in the HUSKY Plan,  
165 Part B to the commissioner who may transmit such data to the

166 Children's Health Council.

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

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

176 [(h)] (k) Not more than twelve months after the determination of  
177 eligibility for benefits under the HUSKY Plan, Part A and Part B and  
178 annually thereafter, the commissioner or the servicer, as the case may  
179 be, shall determine if the child continues to be eligible for the plan. The  
180 commissioner or the servicer shall mail an application form to each  
181 participant in the plan for the purposes of obtaining information to  
182 make a determination on eligibility. To the extent permitted by federal  
183 law, in determining eligibility for benefits under the HUSKY Plan, Part  
184 A and Part B with respect to family income, the commissioner or the  
185 servicer shall rely upon information provided in such form by the  
186 participant unless the commissioner or the servicer has reason to  
187 believe that such information is inaccurate or incomplete. The  
188 determination of eligibility shall be coordinated with health plan open  
189 enrollment periods.

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

193 [(j)] (m) The commissioner shall adopt regulations, in accordance  
194 with chapter 54, to establish residency requirements and income  
195 eligibility for participation in the HUSKY Plan, Part B and procedures  
196 for a simplified mail-in application process. Notwithstanding the

197 provisions of section 17b-257b, such regulations shall provide that any  
198 child adopted from another country by an individual who is a citizen  
199 of the United States and a resident of this state shall be eligible for  
200 benefits under the HUSKY Plan, Part B upon arrival in this state.

201 Sec. 4. (NEW) (*Effective from passage*) (a) The HUSKY Plan, Part B  
202 shall provide the following minimum benefit coverage:

203 (1) No copayments for preventive care and services;

204 (2) No copayments for the following medical services: Inpatient  
205 physician and hospital, outpatient surgical, ambulance for emergency  
206 medical conditions, skilled nursing, home health, hospice, short-term  
207 rehabilitation and physical therapy, occupational and speech therapies,  
208 lab and x-ray, preadmission testing, prosthetics, durable medical  
209 equipment other than powered wheelchairs, dental exams every six  
210 months, x-rays, fillings, fluoride treatments and oral surgery. For the  
211 purposes of this subdivision, in accordance with the National  
212 Committee for Quality Assurance, an emergency medical condition is  
213 a condition such that a prudent layperson, acting reasonably, would  
214 believe that emergency medical treatment is needed;

215 (3) Outpatient physician visits, hearing examinations, nurse  
216 midwives, nurse practitioners, podiatrists, chiropractors and  
217 natureopaths;

218 (4) Prescription drugs;

219 (5) Eye care and optical hardware;

220 (6) Orthodontia;

221 (7) Mental health inpatient maximum of sixty days with allowable  
222 substitution of alternative levels of care and outpatient maximum of  
223 thirty visits with supplemental coverage available under a HUSKY  
224 Plus program for medically eligible enrollees, provided coverage  
225 under the HUSKY Plan, Part B and HUSKY Plus programs shall be

226 consistent with the provisions of the Mental Health Parity Act, Public  
227 Law 104-204, and sections 38a-488a, 38a-514 and 38a-533 of the general  
228 statutes;

229 (8) Substance abuse treatment which shall include, detoxification  
230 and inpatient treatment for drug dependency for a period of time not  
231 to exceed sixty days in a calendar year, detoxification and inpatient  
232 treatment for alcohol dependency for a period of time not to exceed  
233 forty-five days in a calendar year and outpatient visits for drug and  
234 alcohol dependency for a period of time not to exceed sixty days in a  
235 calendar year; and

236 (9) No deductibles shall be charged; no preexisting condition  
237 exclusion shall be applied, and there shall be no coinsurance or annual  
238 or lifetime benefit maximums.

239 (b) The Commissioner of Social Services may establish a schedule of  
240 reasonable copayments for coverage provided under subdivisions (3)  
241 to (8), inclusive, of subsection (a) of this section.

242 Sec. 5. Section 17b-295 of the general statutes, as amended by section  
243 55 of public act 03-3 of the June 30 special session, is repealed and the  
244 following is substituted in lieu thereof (*Effective from passage*):

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

250 [(1) On and after October 1, 2003, the commissioner may increase  
251 the maximum annual aggregate cost sharing requirements provided  
252 that such cost-sharing requirements shall not exceed five per cent of  
253 the family's gross annual income. The commissioner may impose a  
254 premium requirement on families, whose income exceeds one hundred  
255 eighty-five per cent of the federal poverty level as a component of the

256 family's cost-sharing responsibility provided the family's annual  
257 combined premiums and copayments do not exceed the maximum  
258 annual aggregate cost-sharing requirement; and]

259 (1) On and after the effective date of this section, the commissioner  
260 shall submit a schedule for the maximum annual aggregate cost-  
261 sharing for families with an income: (A) Which exceeds one hundred  
262 eighty-five per cent of the federal poverty level but does not exceed  
263 two hundred thirty-five per cent of the federal poverty level, and (B)  
264 which exceeds two hundred thirty-five per cent of the federal poverty  
265 level but does not exceed three hundred per cent of the federal poverty  
266 level to the joint standing committees of the General Assembly having  
267 cognizance of matters relating to human services, public health,  
268 insurance and appropriations and the budgets of state agencies. Not  
269 later than fifteen days after the receipt of such schedule, said joint  
270 standing committees of the General Assembly shall advise the  
271 commissioner of their approval, denial or modifications, if any, of the  
272 schedule. If the joint standing committees do not concur, the  
273 committee chairpersons shall appoint a committee of conference which  
274 shall be comprised of three members from each joint standing  
275 committee. At least one member appointed from each committee shall  
276 be a member of the minority party. The report of the committee of  
277 conference shall be made to each committee, which shall vote to accept  
278 or reject the report. The report of the committee on conference may not  
279 be amended. If a joint standing committee rejects the report of the  
280 committee on conference, the schedule submitted by the commissioner  
281 shall be deemed approved. If the joint standing committees accept the  
282 report, the committee having cognizance of matters relating to  
283 appropriations and the budgets of state agencies shall advise the  
284 commissioner of their approval or modifications, if any, of the  
285 schedule, provided if the committees do not so advise the  
286 commissioner during the fifteen day period, the schedule submitted by  
287 the commissioner shall be deemed approved.

288 (2) The commissioner shall require each managed care plan to

289 monitor copayments and premiums under the provisions of  
290 subdivision (1) of this subsection.

291 (b) (1) Except as provided in subdivision (2) of this subsection, the  
292 commissioner may impose limitations on the amount, duration and  
293 scope of benefits under the HUSKY Plan, Part B.

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

298 (c) The commissioner shall allow persons required to pay a  
299 premium in connection with services provided under the HUSKY,  
300 Plan, Part B to pay such premiums through payroll deductions.

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

305 (c) The commissioner shall, within available appropriations,  
306 contract with qualified entities authorized to grant presumptive  
307 eligibility, severe need schools and community-based organizations for  
308 purposes of public education, outreach and recruitment of eligible  
309 children, including the distribution of applications and information  
310 regarding enrollment in the HUSKY Plan, Part A and Part B. In  
311 awarding such contracts, the commissioner shall consider the  
312 marketing, outreach and recruitment efforts of organizations. For the  
313 purposes of this subsection, (1) "community-based organizations" shall  
314 include, but not be limited to, day care centers, schools, school-based  
315 health clinics, community-based diagnostic and treatment centers and  
316 hospitals, and (2) "severe need school" means a school in which forty  
317 per cent or more of the lunches served are served to students who are  
318 eligible for free or reduced price lunches.

319 Sec. 7. Section 17b-261 of the general statutes, as amended by section  
320 10 public act 03-2, section 2 of public act 03-28, section 7 of public act  
321 03-268 and section 63 of public act 03-3 of the June 30 special session, is  
322 repealed and the following is substituted in lieu thereof (*Effective from*  
323 *passage*):

324 (a) Medical assistance shall be provided for any otherwise eligible  
325 person whose income, including any available support from legally  
326 liable relatives and the income of the person's spouse or dependent  
327 child, is not more than one hundred forty-three per cent, pending  
328 approval of a federal waiver applied for pursuant to subsection (d) of  
329 this section, of the benefit amount paid to a person with no income  
330 under the temporary family assistance program in the appropriate  
331 region of residence and if such person is an institutionalized  
332 individual as defined in Section 1917(c) of the Social Security Act, 42  
333 USC 1396p(c), and has not made an assignment or transfer or other  
334 disposition of property for less than fair market value for the purpose  
335 of establishing eligibility for benefits or assistance under this section.  
336 Any such disposition shall be treated in accordance with Section  
337 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of  
338 property made on behalf of an applicant or recipient or the spouse of  
339 an applicant or recipient by a guardian, conservator, person  
340 authorized to make such disposition pursuant to a power of attorney  
341 or other person so authorized by law shall be attributed to such  
342 applicant, recipient or spouse. A disposition of property ordered by a  
343 court shall be evaluated in accordance with the standards applied to  
344 any other such disposition for the purpose of determining eligibility.  
345 The commissioner shall establish the standards for eligibility for  
346 medical assistance at one hundred forty-three per cent of the benefit  
347 amount paid to a family unit of equal size with no income under the  
348 temporary family assistance program in the appropriate region of  
349 residence, pending federal approval, except that the medical assistance  
350 program shall provide coverage to persons under the age of nineteen  
351 up to one hundred eighty-five per cent of the federal poverty level  
352 without an asset limit. Said medical assistance program shall also

353 provide coverage to persons under the age of nineteen and their  
354 parents and needy caretaker relatives who qualify for coverage under  
355 Section 1931 of the Social Security Act with family income up to one  
356 hundred fifty per cent of the federal poverty level without an asset  
357 limit, upon the request of such a person or upon a redetermination of  
358 eligibility. Such levels shall be based on the regional differences in  
359 such benefit amount, if applicable, unless such levels based on regional  
360 differences are not in conformance with federal law. Any income in  
361 excess of the applicable amounts shall be applied as may be required  
362 by said federal law, and assistance shall be granted for the balance of  
363 the cost of authorized medical assistance. All contracts entered into on  
364 and after July 1, 1997, pursuant to this section shall include provisions  
365 for collaboration of managed care organizations with the Healthy  
366 Families Connecticut Program established pursuant to section 17a-56.  
367 The Commissioner of Social Services shall provide applicants for  
368 assistance under this section, at the time of application, with a written  
369 statement advising them of the effect of an assignment or transfer or  
370 other disposition of property on eligibility for benefits or assistance.

371 (b) For the purposes of the Medicaid program, the Commissioner of  
372 Social Services shall consider parental income and resources as  
373 available to a child under eighteen years of age who is living with his  
374 or her parents and is blind or disabled for purposes of the Medicaid  
375 program, or to any other child under twenty-one years of age who is  
376 living with his or her parents.

377 (c) For the purposes of determining eligibility for the Medicaid  
378 program, an available asset is one that is actually available to the  
379 applicant or one that the applicant has the legal right, authority or  
380 power to obtain or to have applied for the applicant's general or  
381 medical support. If the terms of a trust provide for the support of an  
382 applicant, the refusal of a trustee to make a distribution from the trust  
383 does not render the trust an unavailable asset. Notwithstanding the  
384 provisions of this subsection, the availability of funds in a trust or  
385 similar instrument funded in whole or in part by the applicant or the

386 applicant's spouse shall be determined pursuant to the Omnibus  
387 Budget Reconciliation Act of 1993, 42 USC 1396p. The provisions of  
388 this subsection shall not apply to special needs trust, as defined in 42  
389 USC 1396p(d)(4)(A).

390 (d) The transfer of an asset in exchange for other valuable  
391 consideration shall be allowable to the extent the value of the other  
392 valuable consideration is equal to or greater than the value of the asset  
393 transferred.

394 (e) The Commissioner of Social Services shall seek a waiver from  
395 federal law to permit federal financial participation for Medicaid  
396 expenditures for families with incomes of one hundred forty-three per  
397 cent of the temporary family assistance program payment standard.

398 [(f) Notwithstanding the provisions of subsection (a) of this section,  
399 on or after April 1, 2003, all parent and needy caretaker relatives with  
400 incomes exceeding one hundred per cent of the federal poverty level,  
401 who are receiving medical assistance pursuant to this section, shall be  
402 ineligible for such medical assistance. On and after February 28, 2003,  
403 the Department of Social Services shall not accept applications for  
404 medical assistance program coverage under Section 1931 of the Social  
405 Security Act from parent and needy caretaker relatives with incomes  
406 exceeding one hundred per cent of the federal poverty level until on or  
407 after July 1, 2005.]

408 [(g)] (f) To the extent permitted by federal law, Medicaid eligibility  
409 shall be extended for two years to a family who becomes ineligible for  
410 medical assistance under Section 1931 of the Social Security Act while  
411 employed or due to receipt of child support income or a family with an  
412 adult who, within six months of becoming ineligible under Section  
413 1931 of the Social Security Act becomes employed.

414 [(h) An institutionalized spouse applying for Medicaid and having a  
415 spouse living in the community shall be required, to the maximum  
416 extent permitted by law, to divert income to such community spouse

417 in order to raise the community spouse's income to the level of the  
418 minimum monthly needs allowance, as described in Section 1924 of  
419 the Social Security Act. Such diversion of income shall occur before the  
420 community spouse is allowed to retain assets in excess of the  
421 community spouse protected amount described in Section 1924 of the  
422 Social Security Act. The Commissioner of Social Services, pursuant to  
423 section 17b-10, may implement the provisions of this subsection while  
424 in the process of adopting regulations, provided the commissioner  
425 prints notice of intent to adopt the regulations in the Connecticut Law  
426 Journal within twenty days of adopting such policy. Such policy shall  
427 be valid until the time final regulations are effective.]

428 Sec. 8. (*Effective from passage*) Section 12 of public act 03-2 and  
429 sections 69 and 72 of public act 03-3 of the June 30 special session are  
430 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>

**HS**

**Joint Favorable C/R**

**APP**