



House of Representatives

General Assembly

File No. 315

February Session, 2006

Substitute House Bill No. 5595

House of Representatives, April 3, 2006

The Committee on Insurance and Real Estate reported through REP. O'CONNOR of the 35th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING THE HEALTHY KIDS INITIATIVE.

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

1 Section 1. Section 17b-261 of the 2006 supplement to the general
2 statutes is repealed and the following is substituted in lieu thereof
3 (*Effective July 1, 2006*):

4 (a) Medical assistance shall be provided for any otherwise eligible
5 person whose income, including any available support from legally
6 liable relatives and the income of the person's spouse or dependent
7 child, is not more than one hundred forty-three per cent, pending
8 approval of a federal waiver applied for pursuant to subsection (d) of
9 this section, of the benefit amount paid to a person with no income
10 under the temporary family assistance program in the appropriate
11 region of residence and if such person is an institutionalized
12 individual as defined in Section 1917(c) of the Social Security Act, 42
13 USC 1396p(c), and has not made an assignment or transfer or other
14 disposition of property for less than fair market value for the purpose

15 of establishing eligibility for benefits or assistance under this section.
16 Any such disposition shall be treated in accordance with Section
17 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
18 property made on behalf of an applicant or recipient or the spouse of
19 an applicant or recipient by a guardian, conservator, person
20 authorized to make such disposition pursuant to a power of attorney
21 or other person so authorized by law shall be attributed to such
22 applicant, recipient or spouse. A disposition of property ordered by a
23 court shall be evaluated in accordance with the standards applied to
24 any other such disposition for the purpose of determining eligibility.
25 The commissioner shall establish the standards for eligibility for
26 medical assistance at one hundred forty-three per cent of the benefit
27 amount paid to a family unit of equal size with no income under the
28 temporary family assistance program in the appropriate region of
29 residence, pending federal approval, except that the medical assistance
30 program shall provide coverage to persons under the age of nineteen
31 up to one hundred eighty-five per cent of the federal poverty level
32 without an asset limit. Said medical assistance program shall also
33 provide coverage to persons under the age of nineteen and their
34 parents and needy caretaker relatives who qualify for coverage under
35 Section 1931 of the Social Security Act with family income up to one
36 hundred fifty per cent of the federal poverty level without an asset
37 limit, upon the request of such a person or upon a redetermination of
38 eligibility. Such levels shall be based on the regional differences in
39 such benefit amount, if applicable, unless such levels based on regional
40 differences are not in conformance with federal law. Any income in
41 excess of the applicable amounts shall be applied as may be required
42 by said federal law, and assistance shall be granted for the balance of
43 the cost of authorized medical assistance. All contracts entered into on
44 and after July 1, 1997, pursuant to this section shall include provisions
45 for collaboration of managed care organizations with the Healthy
46 Families Connecticut Program established pursuant to section 17a-56,
47 as amended. The Commissioner of Social Services shall provide
48 applicants for assistance under this section, at the time of application,
49 with a written statement advising them of the effect of an assignment

50 or transfer or other disposition of property on eligibility for benefits or
51 assistance.

52 (b) For the purposes of the Medicaid program, the Commissioner of
53 Social Services shall consider parental income and resources as
54 available to a child under eighteen years of age who is living with his
55 or her parents and is blind or disabled for purposes of the Medicaid
56 program, or to any other child under twenty-one years of age who is
57 living with his or her parents.

58 (c) For the purposes of determining eligibility for the Medicaid
59 program, an available asset is one that is actually available to the
60 applicant or one that the applicant has the legal right, authority or
61 power to obtain or to have applied for the applicant's general or
62 medical support. If the terms of a trust provide for the support of an
63 applicant, the refusal of a trustee to make a distribution from the trust
64 does not render the trust an unavailable asset. Notwithstanding the
65 provisions of this subsection, the availability of funds in a trust or
66 similar instrument funded in whole or in part by the applicant or the
67 applicant's spouse shall be determined pursuant to the Omnibus
68 Budget Reconciliation Act of 1993, 42 USC 1396p. The provisions of
69 this subsection shall not apply to special needs trust, as defined in 42
70 USC 1396p(d)(4)(A).

71 (d) The transfer of an asset in exchange for other valuable
72 consideration shall be allowable to the extent the value of the other
73 valuable consideration is equal to or greater than the value of the asset
74 transferred.

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

79 (f) To the extent permitted by federal law, Medicaid eligibility shall
80 be extended for one year to a family that becomes ineligible for
81 medical assistance under Section 1931 of the Social Security Act due to

82 income from employment by one of its members who is a caretaker
83 relative is employed or due to receipt of child support income. A
84 family receiving extended benefits on July 1, 2005, shall receive the
85 balance of such extended benefits, provided no such family shall
86 receive more than twelve additional months of such benefits.

87 (g) An institutionalized spouse applying for Medicaid and having a
88 spouse living in the community shall be required, to the maximum
89 extent permitted by law, to divert income to such community spouse
90 in order to raise the community spouse's income to the level of the
91 minimum monthly needs allowance, as described in Section 1924 of
92 the Social Security Act. Such diversion of income shall occur before the
93 community spouse is allowed to retain assets in excess of the
94 community spouse protected amount described in Section 1924 of the
95 Social Security Act. The Commissioner of Social Services, pursuant to
96 section 17b-10, may implement the provisions of this subsection while
97 in the process of adopting regulations, provided the commissioner
98 prints notice of intent to adopt the regulations in the Connecticut Law
99 Journal within twenty days of adopting such policy. Such policy shall
100 be valid until the time final regulations are effective.

101 [(h) The Commissioner of Social Services shall, to the extent
102 permitted by federal law, or, pursuant to an approved waiver of
103 federal law submitted by the commissioner, in accordance with the
104 provisions of section 17b-8, impose the following cost-sharing
105 requirements under the HUSKY Plan, on all parent and needy
106 caretaker relatives with incomes exceeding one hundred per cent of the
107 federal poverty level: (1) A twenty-five-dollar premium per month per
108 parent or needy caretaker relative; and (2) a copayment of one dollar
109 per visit for outpatient medical services delivered by an enrolled
110 Medicaid or HUSKY Plan provider. The commissioner may implement
111 policies and procedures necessary to administer the provisions of this
112 subsection while in the process of adopting such policies and
113 procedures as regulations, provided the commissioner publishes notice
114 of the intent to adopt regulations in the Connecticut Law Journal not
115 later than twenty days after implementation. Policies and procedures

116 implemented pursuant to this subsection shall be valid until the time
117 final regulations are adopted.]

118 [(i)] (h) Medical assistance shall be provided, in accordance with the
119 provisions of subsection (e) of section 17a-6, to any child under the
120 supervision of the Commissioner of Children and Families who is not
121 receiving Medicaid benefits, has not yet qualified for Medicaid benefits
122 or is otherwise ineligible for such benefits because of institutional
123 status. To the extent practicable, the Commissioner of Children and
124 Families shall apply for, or assist such child in qualifying for, the
125 Medicaid program.

126 (i) The Commissioner of Social Services shall provide Early and
127 Periodic, Screening, Diagnostic and Treatment program services, as
128 required by 42 USC 1396a(a)(43), 42 USC 1396d(r) and 42 USC
129 1396d(a)(4)(B) and applicable federal regulations to all persons who
130 are under the age of twenty-one and otherwise eligible for medical
131 assistance under this section.

132 Sec. 2. Section 17b-292 of the 2006 supplement to the general statutes
133 is repealed and the following is substituted in lieu thereof (*Effective July*
134 *1, 2006*):

135 (a) A child who resides in a household with a family income which
136 exceeds one hundred eighty-five per cent of the federal poverty level
137 and does not exceed three hundred per cent of the federal poverty
138 level may be eligible for subsidized benefits under the HUSKY Plan,
139 Part B.

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

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

146 (d) A child who has been determined to be eligible for benefits

147 under either the HUSKY Plan, Part A or Part B shall remain eligible for
148 such plan for a period of twelve months from such child's
149 determination of eligibility unless the child attains the age of nineteen
150 or is no longer a resident of the state. During the twelve-month period
151 following the date that a child is determined eligible for the HUSKY
152 Plan, Part A or Part B, the department shall not require the family of
153 such child to report changes in family income or family composition.

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

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

162 [(f)] (g) The commissioner shall implement presumptive eligibility
163 for children applying for Medicaid. Such presumptive eligibility
164 determinations shall be in accordance with applicable federal law and
165 regulations. The commissioner shall adopt regulations, in accordance
166 with chapter 54, to establish standards and procedures for the
167 designation of organizations as qualified entities to grant presumptive
168 eligibility. Qualified entities shall ensure that, at the time a
169 presumptive eligibility determination is made, a completed application
170 for Medicaid is submitted to the department for a full eligibility
171 determination. In establishing such standards and procedures, the
172 commissioner shall ensure the representation of state-wide and local
173 organizations that provide services to children of all ages in each
174 region of the state.

175 [(g)] (h) The commissioner shall enter into a contract with an entity
176 to be a single point of entry servicer for applicants and enrollees under
177 the HUSKY Plan, Part A and Part B. The servicer shall jointly market
178 both Part A and Part B together as the HUSKY Plan. Such servicer shall
179 develop and implement public information and outreach activities

180 with community programs. Such servicer shall electronically transmit
181 data with respect to enrollment and disenrollment in the HUSKY Plan,
182 Part B to the commissioner.

183 [(h)] (i) Upon the expiration of any contractual provisions entered
184 into pursuant to subsection [(g)] (h) of this section, the commissioner
185 shall develop a new contract for single point of entry services and
186 managed care enrollment brokerage services. The commissioner may
187 enter into one or more contractual arrangements for such services for a
188 contract period not to exceed seven years. Such contracts shall include
189 performance measures, including, but not limited to, specified time
190 limits for the processing of applications, parameters setting forth the
191 requirements for a completed and reviewable application and the
192 percentage of applications forwarded to the department in a complete
193 and timely fashion. Such contracts shall also include a process for
194 identifying and correcting noncompliance with established
195 performance measures, including sanctions applicable for instances of
196 continued noncompliance with performance measures.

197 [(i)] (j) The single point of entry servicer shall send an application
198 and supporting documents to the commissioner for determination of
199 eligibility of a child who resides in a household with a family income
200 of one hundred eighty-five per cent or less of the federal poverty level.
201 The servicer shall enroll eligible beneficiaries in the applicant's choice
202 of managed care plan. Upon enrollment in a managed care plan, an
203 eligible HUSKY Plan Part A or Part B beneficiary shall remain enrolled
204 in such managed care plan for twelve months from the date of such
205 enrollment unless (1) an eligible beneficiary demonstrates good cause
206 to the satisfaction of the commissioner of the need to enroll in a
207 different managed care plan, or (2) the beneficiary no longer meets
208 program eligibility requirements.

209 [(j)] (k) Not more than twelve months after the determination of
210 eligibility for benefits under the HUSKY Plan, Part A and Part B and
211 annually thereafter, the commissioner or the servicer, as the case may
212 be, shall determine if the child continues to be eligible for the plan. The

213 commissioner or the servicer shall mail an application form to each
214 participant in the plan for the purposes of obtaining information to
215 make a determination on eligibility. To the extent permitted by federal
216 law, in determining eligibility for benefits under the HUSKY Plan, Part
217 A or Part B with respect to family income, the commissioner or the
218 servicer shall rely upon information provided in such form by the
219 participant unless the commissioner or the servicer has reason to
220 believe that such information is inaccurate or incomplete. The
221 determination of eligibility shall be coordinated with health plan open
222 enrollment periods.

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

226 [(l)] (m) The commissioner shall adopt regulations, in accordance
227 with chapter 54, to establish residency requirements and income
228 eligibility for participation in the HUSKY Plan, Part B and procedures
229 for a simplified mail-in application process. Notwithstanding the
230 provisions of section 17b-257b, such regulations shall provide that any
231 child adopted from another country by an individual who is a citizen
232 of the United States and a resident of this state shall be eligible for
233 benefits under the HUSKY Plan, Part B upon arrival in this state.

234 Sec. 3. (NEW) (*Effective October 1, 2006*) Not later than October 1,
235 2007, each health care provider licensed in this state shall submit
236 claims or requests for payment to insurance companies with respect to
237 medical services and treatment rendered by such provider in this state,
238 in electronic format.

239 Sec. 4. (NEW) (*Effective October 1, 2006*) No physician licensed under
240 chapter 370 of the general statutes who does not have a contract with a
241 third party payer or who provides medical services or treatment to
242 persons who do not have health insurance coverage shall charge fees
243 for such services or treatment that exceed two hundred per cent of
244 those fees allowed by the federal Medicare program for such services
245 or treatment.

246 Sec. 5. (NEW) (*Effective October 1, 2006*) Each physician licensed
247 under chapter 370 of the general statutes and engaged in the private
248 practice of medicine in this state shall:

249 (1) Post, in public view within the waiting room in such physician's
250 office, in a conspicuous manner, a list of the twenty procedures most
251 frequently performed in such office for such physician's specialty and
252 the current charges for each such procedures;

253 (2) Provide, upon request of the patient or such patient's designee,
254 an estimate of the costs of any service or treatment to the patient or his
255 or her designee prior to the service or treatment being rendered; and

256 (3) Provide an itemized receipt to the patient or such patient's
257 designee for any payment made at such physician's office by or on
258 behalf of such patient, which shall specify the services rendered to the
259 patient and the charges for each such service.

260 Sec. 6. (NEW) (*Effective October 1, 2006*) (a) The Commissioner of
261 Public Health and the Insurance Commissioner, in consultation with
262 licensed providers of health care, health insurance companies doing
263 business in this state and consumers designated by said
264 commissioners, shall create a physician report card which shall contain
265 data relative to generally accepted performance measures designed to
266 allow the Department of Public Health to provide consumers with
267 information on the performance of physicians and the effectiveness of
268 care provided by each physician and to permit consumers and
269 insurance companies to compare physicians by criteria concerning
270 quality.

271 (b) Each physician licensed under chapter 370 of the general statutes
272 shall furnish any information required by the Commissioner of Public
273 Health, upon the request of said commissioner, relative to performance
274 measures. Said commissioner shall publish such information and
275 comparative data on the Internet web site of the Department of Public
276 Health.

277 Sec. 7. Section 38a-476c of the 2006 supplement to the general
278 statutes is repealed and the following is substituted in lieu thereof
279 (*Effective October 1, 2006*):

280 (a) The Insurance Commissioner shall approve any health insurance
281 policy or contract, including, but not limited to, a policy or contract
282 filed by a health care center, that uses variable networks and enrollee
283 cost-sharing as set forth in subsection (b) of this section if (1) the policy
284 or contract meets the requirements of this title, (2) the policy or
285 contract form or amendment thereto filed with the commissioner is
286 accompanied by a rate filing for the policy or contract and (3) the
287 commissioner finds that the rate filing reflects a reasonable reduction
288 in premiums or fees as compared to policies or contracts that do not
289 use such variable networks and enrollee cost-sharing.

290 (b) Such policies and contracts shall be limited to policies and
291 contracts that: (1) Offer choices among provider networks of different
292 size; (2) offer different deductibles depending on the type of health
293 care facility used; [or] (3) offer prescription drug benefits that use any
294 combination of deductibles, coinsurance not to exceed thirty per cent
295 or copayments, including combinations of such deductibles,
296 coinsurance or copayments at different benefit levels; or (4) require the
297 use of a mail order pharmacy.

298 Sec. 8. Subparagraph (B) of subdivision (15) of section 38a-816 of the
299 2006 supplement to the general statutes is repealed and the following
300 is substituted in lieu thereof (*Effective October 1, 2007*):

301 (B) Each insurer, or other entity responsible for providing payment
302 to a health care provider pursuant to an insurance policy subject to this
303 section, shall pay claims not later than forty-five days after receipt by
304 the insurer of the claimant's proof of loss form or the health care
305 provider's request for payment filed in accordance with the insurer's
306 practices or procedures provided such request is in electronic format,
307 except that when there is a deficiency in the information needed for
308 processing a claim, as determined in accordance with section 38a-477,
309 the insurer shall (i) send written notice to the claimant or health care

310 provider, as the case may be, of all alleged deficiencies in information
311 needed for processing a claim not later than thirty days after the
312 insurer receives a claim for payment or reimbursement under the
313 contract, and (ii) pay claims for payment or reimbursement under the
314 contract not later than thirty days after the insurer receives the
315 information requested.

316 Sec. 9. (NEW) (*Effective from passage*) Not later than January 1, 2007,
317 the Commissioner of Social Services, in consultation with the Medicaid
318 managed care organizations administering the HUSKY Plan, Part A, as
319 defined in section 17b-290 of the 2006 supplement to the general
320 statutes, shall establish a medical home pilot program in one region of
321 the state to be determined by said commissioner in order to enhance
322 health outcomes for children, including children with special health
323 care needs, by ensuring that each child has a primary care physician
324 who will provide comprehensive health care services and referrals for
325 such child, including specialty services as needed. Said commissioner
326 shall reimburse primary care physicians under such pilot program for
327 the following: (1) Physician services that reduce preventable
328 emergency room visits, hospitalizations and urgent care services; (2)
329 care coordination and case management by other physicians, nurse
330 practitioners or physician assistants in treating presenting conditions
331 during a well-child visit with appropriate documentation; and (3)
332 services rendered by health and community agency professionals
333 serving a child and his or her family to coordinate patient care for the
334 medical management of specific diseases and health conditions that
335 are clinically serious or affect functionality.

336 Sec. 10. (*Effective October 1, 2006*) Not later than January 1, 2008, the
337 Commissioner of Social Services, in conjunction with the
338 Commissioner of Public Health, shall evaluate the medical home pilot
339 program established under section 9 of this act to ascertain specific
340 improved health outcomes and any cost efficiencies achieved and shall
341 make recommendations to incorporate reimbursement for services
342 described in subdivisions (1) to (3), inclusive, of section 9 of this act
343 into the HUSKY Plan, Part A fee schedule. Not later than February 1,

344 2008, the Commissioner of Social Services shall submit a report to the
 345 joint standing committees of the General Assembly having cognizance
 346 of matters relating to human services, public health and appropriations
 347 and the budgets of state agencies on the evaluation of such pilot
 348 program and such recommendations.

349 Sec. 11. (*Effective July 1, 2006*) The sum of one hundred thousand
 350 dollars is appropriated to the Department of Social Services, from the
 351 General Fund, for the fiscal year ending June 30, 2007, for the purpose
 352 of providing the department with the funds to implement the public
 353 information and outreach activities specified in section 17b-297 of the
 354 general statutes.

355 Sec. 12. Section 17b-261c of the general statutes is repealed. (*Effective*
 356 *July 1, 2006*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2006</i>	17b-261
Sec. 2	<i>July 1, 2006</i>	17b-292
Sec. 3	<i>October 1, 2006</i>	New section
Sec. 4	<i>October 1, 2006</i>	New section
Sec. 5	<i>October 1, 2006</i>	New section
Sec. 6	<i>October 1, 2006</i>	New section
Sec. 7	<i>October 1, 2006</i>	38a-476c
Sec. 8	<i>October 1, 2007</i>	38a-816(15)(B)
Sec. 9	<i>from passage</i>	New section
Sec. 10	<i>October 1, 2006</i>	New section
Sec. 11	<i>July 1, 2006</i>	New section
Sec. 12	<i>July 1, 2006</i>	Repealer section

INS *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 07 \$	FY 08 \$
Department of Social Services	GF - Cost	Significant	Significant
Public Health, Dept.	GF - Cost	178,625- 203,625	130,500
Comptroller Misc. Accounts (Fringe Benefits)	GF - Cost	17,850	70,550
Insurance Dept.	IF - None	None	None

Note: GF=General Fund; IF=Insurance Fund

Municipal Impact: None

Explanation

Section 1 of this bill eliminates the \$25 monthly premium and the \$1 outpatient service co-payments for parents in the HUSKY program with incomes over 100% of the federal poverty level. It is estimated that as a result of the state paying the full premium, as well as an anticipated increase in enrollment, this change will increase costs to the HUSKY program by \$8 million to \$10 million annually.

This section also specifies that the Department of Social Services (DSS) provide Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) services to medical assistance recipients under the age of 21. As this is currently required under federal law, it is not expected to change any aspect of the current services provided by DSS.

Section 2 of the bill re-establishes the continuous eligibility policy for children in the HUSKY plan. This change is expected to cost approximately \$2 million annually.

Section 2 also re-establishes the self-declaration of income policy for the HUSKY program. Based on the changes in enrollment since this policy was repealed, this policy is expected to increase enrollment by

approximately 2,500 individuals, at an annual cost of \$6 million.

Sections 3 to 5 create new mandates on physicians concerning submittal of insurance claims, the posting of charges, and maximum charges for uninsured patients. These changes are not expected to have a direct fiscal impact on the state.

Section 6 requires the Departments of Public Health (DPH) and Insurance (DOI), in consultation with licensed health care providers, health insurance companies and consumers, to create and implement a physician report card.

One-time costs of approximately \$92,500 - \$117,500 will be incurred by the DPH in FY 07. This includes \$75,000 - \$100,000 associated with retaining consultant services needed to facilitate development of physician specific performance measures for different treatment settings, \$7,500 for publication and mailing of physician-specific reporting instructions brochures, and \$10,000 for systems development.

The DPH will incur additional FY 07 costs of \$86,125 to support the partial year salaries of one Epidemiologist and one Nurse Consultant needed to analyze the reported data, evaluate the measures for modification, and follow-up with physicians; as well as associated other expenses and equipment costs.

The annualized cost to the department will be approximately \$130,500 in FY 08 and subsequent years to support the continuing salaries and other expenses. Associated fringe benefits costs of \$17,850 in FY 07 and \$70,550 in FY 08 will also be incurred¹.

¹ The fringe benefit costs for state employees are budgeted centrally in the Miscellaneous Accounts administered by the Comptroller. The estimated first year fringe benefit rate as a percentage of payroll is 23.6%, effective July 1, 2005. The first year fringe benefit costs for new positions do not include pension costs. The state's pension contribution is based upon the prior year's certification by the actuary for the State Employees Retirement System (SERS). The SERS 2005-06 fringe benefit rate is 34.7%, which when combined with the non pension fringe benefit rate would total 58.3%.

It is anticipated that the DOI will be able to consult on the creation of the physician report card within existing resources.

No funding has been included within sHB 5007 (the Revised FY 07 Appropriations Act, as favorably reported by the Appropriations Committee) to implement this section.

Section 9 of the bill requires DSS to establish a medical home pilot program. This pilot is expected to result in additional costs to the department. The extent of these costs will depend upon the number of children enrolled in the pilot and the rates that are established for services provided under the pilot. These factors are not specified in the bill, and therefore an exact cost cannot be estimated, although it is expected to be significant. The HUSKY program may also realize savings if this pilot program succeeds in improving children's health outcomes and avoiding more costly care. The extent of these savings cannot be estimated. **Section 10** of the bill requires DSS and DPH to evaluate this pilot program and submit a report to the General Assembly. The departments will incur a one-time cost to meet these requirements, the extent of which will be dependent upon the size of the pilot.

Section 11 appropriates \$100,000 to DSS for public information and outreach activities.

Section 12 repeals the section of statute that prohibits guaranteed eligibility in the Medicaid program. It is not clear that by repealing the prohibition the bill restores the guaranteed eligibility policy. Should this policy be restored, it is estimated that the Medicaid program will incur additional expenses of approximately \$2 million annually.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis**sHB 5595*****AN ACT CONCERNING THE HEALTHY KIDS INITIATIVE.*****SUMMARY:**

This bill makes several changes affecting HUSKY. It:

1. eliminates the cost-sharing requirements added in 2005 for parents and caretaker relatives receiving "HUSKY" with incomes over 100% of the federal poverty level;
2. restores the HUSKY A and B continuous eligibility provision eliminated in 2003;
3. restores the HUSKY A and B self-declaration of income requirement eliminated in 2005;
4. repeals the HUSKY A guaranteed eligibility prohibition enacted in 2003;
5. requires the Department of Social Services (DSS) commissioner to provide people under age 21 and eligible for Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services (including medical, vision, dental, and hearing services), which are required under federal law;
6. appropriates \$100,000 to DSS for additional public information and outreach activities required by law;
7. requires the DSS commissioner to establish a medical home pilot program by January 1, 2007; and
8. requires the DSS and public health commissioners to evaluate the medical home pilot program by January 1, 2008 and report

recommendations to the legislature by February 1, 2008.

The bill includes several new requirements for health care providers. Specifically, it prohibits a physician who provides services to uninsured patients or does not contract with a third-party payer (e.g., an insurance company) from charging fees that are more than 200% of the fees allowed under the federal Medicare program. It requires a physician in private practice to (1) display the cost of the most frequently performed procedures; (2) provide a cost estimate upon request before rendering service; and (3) provide itemized receipts. It requires Connecticut-licensed health care providers to submit payment requests to insurance companies in electronic format by October 1, 2007. After that date, it limits the application of Connecticut's 45-day prompt payment requirement to requests sent electronically. (Thus, it eliminates the prompt pay requirement for requests submitted on paper.)

The bill requires the public health and insurance commissioners to create a physician report card that informs consumers about a physician's service quality. Physicians must give the public health commissioner any information needed to measure performance. The public health commissioner must publish the report card on the Department of Public Health's web site.

Finally, the bill expands the permissible benefit design for variable benefit plans, permitted under PA 05-238, by letting such plans require a covered person to use a mail order pharmacy.

EFFECTIVE DATE: July 1, 2006, except (1) the medical home pilot is effective upon passage; (2) provisions regarding the medical home pilot evaluation and report, electronic claim submission, physician requirements, physician report card, and variable benefit plans are effective October 1, 2006; and (3) the prompt claim payment change is effective October 1, 2007.

HUSKY

Cost-Sharing

The bill eliminates the HUSKY A cost-sharing requirements imposed by PA 05-280 but not implemented. That act requires the DSS commissioner, to the extent permitted by federal law or waiver, to impose cost-sharing requirements on parents and caretaker relatives receiving HUSKY (presumably HUSKY A since HUSKY B is only for children) with incomes over 100% of the FPL. The cost-sharing includes (1) a \$25 monthly premium and (2) \$1 co-payment for outpatient medical services.

Continuous Eligibility

The bill requires a child eligible for HUSKY Parts A or B benefits to remain eligible for one year from his eligibility determination date unless he reaches age 19 or moves out of state. The bill prohibits DSS from requiring the child's family to report family income or composition changes during that one year. (PA 03-2 eliminated this continuous eligibility provision.)

Medicaid Guaranteed Eligibility

The bill repeals the statute that prohibits guaranteed eligibility in the Medicaid program. Prior to the prohibition, which was enacted in PA 03-2, regulations allowed adults determined eligible for benefits to remain eligible for six months even if a change in status (such as income) during that time would otherwise make them ineligible. It appears that those regulations are no longer in effect.

Self-Declaration of Income

The bill requires the DSS commissioner, to the extent permitted by federal law, to rely on income information HUSKY A and B applicants put on the program renewal application unless she has reason to believe it is inaccurate or incomplete. (PA 05-280 eliminated this self-declaration requirement.)

Medical Home Pilot Program

The bill requires the DSS commissioner, in consultation with the managed care organizations administering the HUSKY A program, to establish a medical home pilot program in one Connecticut region by

January 1, 2007. The program is to enhance the health outcomes of children, including those with special needs, by ensuring that each child has a primary care physician (PCP) to provide comprehensive health care services and referrals for necessary specialty and other services.

The commissioner must reimburse participating PCPs for pilot-related (1) services that reduce preventable emergency room visits, hospitalizations, and urgent care services; (2) care coordination and case management by other physicians, nurse practitioners, or physician assistants treating conditions present during a well-child visit with appropriate documentation; and (3) health and community agency services given a child and his family to coordinate patient care for specific diseases and conditions that affect the child's functioning or are clinically serious.

The DSS and public health commissioners must, by January 1, 2008, (1) evaluate the pilot program to determine improved health outcomes and any cost efficiencies, and make recommendations to add the specified PCP service reimbursements into the HUSKY A fee schedule. (Because HUSKY A is a managed care plan, the commissioner does not set the fee schedule; she would presumably recommend renegotiating the contracts with the managed care organizations.) By February 1, 2008, the commissioners must report to the Human Services, Public Health, and Appropriations committees on their evaluation and recommendations.

PROVIDER CHARGES AND RECEIPTS

The bill requires a physician in private practice to post in his office waiting room the 20 procedures most frequently performed in his office for his specialty and the current charge for each. It requires the physician to give, upon request of a patient or his designee, a cost estimate before a service or treatment is rendered. The physician must also provide an itemized receipt to the patient, or his designee, for any payment he makes at the physician's office. The receipt must specify the services rendered to the patient and the charge for each.

PROMPT PAY REQUIREMENTS

By law, insurers and other entities responsible for paying health care providers under an insurance policy must pay claims within 45 days after the claimant's insurer receives the (1) claimant's proof of loss form (claim form) or (2) provider's request for payment. When the claim contains a deficiency (e.g., does not contain all the information needed to process it), the insurer must (1) request the additional information needed from the claimant or provider in writing within 30 days after receiving the claim and (2) pay the claim within 30 days of receiving the information needed. Insurers and others that do not pay claims within these times must pay 15% interest plus any other penalty that may be imposed. A violation is an unfair and deceptive insurance practice. The insurance commissioner, after notice and hearing, may (1) issue a "cease and desist" order, (2) impose a fine of up to \$1,000 for each violation or up to \$10,000 for egregious acts, (3) suspend or revoke a license, or (4) demand restitution.

The bill requires Connecticut-licensed health care providers to submit payment requests to insurance companies in electronic format by October 1, 2007. On and after that date, and with respect to providers' requests for payment, the bill limits the 45 day payment timeframe (and, therefore, related penalties for not complying) to requests submitted electronically. Thus, an insurer is not required to pay a provider's request for payment submitted in paper format within a specified time period.

PHYSICIAN REPORT CARD

The bill requires the public health and insurance commissioners, in consultation with licensed health care providers, health insurance companies, and consumers, to create a physician report card that has data on generally accepted performance measures that provide consumers information on the quality of care physicians rendered to patients. It requires physicians to give the public health commissioner any information he requests about their performance. The commissioner must publish this information and the comparative data (i.e., the report card) on the Department of Public Health's web site.

VARIABLE BENEFIT PLANS

PA 05-238 requires the insurance commissioner to approve health insurance plans that offer a variable benefit design if the (1) policy or contract complies with all state insurance laws, (2) insurer or HMO files the policy or contract and associated rates with the commissioner, and (3) rate filing demonstrates a reasonable premium rate reduction compared to a policy or contract that does not use the variable design.

It limits how an insurer or HMO can design such a plan. It can offer (1) a choice of different sized provider networks; (2) different deductibles depending on the type of health facility used; or (3) prescription drug benefits that use a combination of deductibles, coinsurance (up to 30%), or copayments, including at different benefit levels.

The bill permits variable benefit plans to also require the use of a mail order pharmacy.

BACKGROUND***EPSDT***

Under federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, state Medicaid programs (HUSKY A in Connecticut) must provide comprehensive health and developmental assessments and vision, dental, and hearing services to children and youth up to age 21.

The medical screen must include a comprehensive physical and mental health and developmental assessment and history; a comprehensive unclothed medical examination; appropriate immunizations; laboratory tests, including lead blood testing; and health guidance.

Other EPSDT services include eye examinations and eye glasses; teeth restoration and maintenance of dental health; and diagnosis and treatment of hearing problems, including hearing aids.

Public Information and Outreach Activities

By law, the DSS commissioner must develop outreach mechanisms for HUSKY A and B to maximize enrollment and the use of federal funds. These mechanisms must include, at a minimum, mail-in applications and outreach material distributed through various state agencies. Within available appropriations, the commissioner must contract for outreach, public education, recruitment of eligible children, application distribution, and enrollment information. The commissioner must approve all outreach material. She must submit a yearly report to the governor and legislature on the outreach efforts and their effects (CGS § 17b-297).

Related Bill

SB 475 makes the same changes affecting HUSKY as this bill, except it (2) does not require a medical home pilot program and (2) with respect to a child’s 12-month continuous eligibility, requires the child’s family to comply with federal requirements for reporting information to DSS, including change of address information.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 18 Nay 0 (03/16/2006)