



House of Representatives

General Assembly

File No. 831

January Session, 2007

Substitute House Bill No. 6652

House of Representatives, May 16, 2007

The Committee on Appropriations reported through REP. MERRILL of the 54th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT ESTABLISHING THE CONNECTICUT HEALTHY STEPS PROGRAM.

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

1 Section 1. (NEW) (*Effective July 1, 2007*) This act shall be known as
2 the Connecticut Healthy Steps Program.

3 Sec. 2. (NEW) (*Effective July 1, 2007*) (a) There is established a
4 permanent Health Care Reform Commission, which shall be an
5 independent body within the Office of Health Care Access for
6 administrative purposes only. The commission shall consist of the
7 Commissioners of Social Services and Health Care Access, the
8 Insurance Commissioner, or their designees, and nine additional
9 members as follows: One member to be appointed by the Governor,
10 two to be appointed by the president pro tempore of the Senate, two to
11 be appointed by the speaker of the House of Representatives, one to be
12 appointed by the majority leader of the Senate, one to be appointed by
13 the majority leader of the House of Representatives, one to be
14 appointed by the minority leader of the Senate, and one to be
15 appointed by the minority leader of the House of Representatives.

16 (b) Notwithstanding the provisions of subsection (c) of section 4-9a
17 of the general statutes, the members of the commission shall serve for
18 staggered terms. The initial members selected shall serve as follows: (1)
19 The members appointed by the Governor and the president pro
20 tempore of the Senate shall serve for three years; (2) the members
21 appointed by the speaker of the House of Representatives and the
22 majority leader of the Senate shall serve for two years; and (3) the
23 members appointed by the majority leader and the minority leader of
24 the House of Representatives and the minority leader of the Senate
25 shall serve for one year. Following the expiration of such initial terms,
26 each subsequent appointee shall serve for a term of three years. Any
27 vacancy shall be filled by the appointing authority for the unexpired
28 portion of the term of the member replaced. The members shall serve
29 without compensation for their services but shall be reimbursed for
30 their expenses.

31 (c) The commission shall: (1) Not later than July 1, 2008, develop an
32 affordable health care plan that may be sold to employers of fifty or
33 fewer employees through the Connecticut Connector, and if such
34 employer makes such plan available to such employees, such
35 employer shall qualify for a tax credit pursuant to section 6 of this act,
36 (2) not later than July 1, 2008, develop a comprehensive health care
37 plan, as described in section 38a-555 of the general statutes, that an
38 employer of fifty or fewer employees shall make available to
39 employees in order to qualify for a tax credit pursuant to section 7 of
40 this act, (3) not later than January 1, 2009, submit a report to the joint
41 standing committee of the General Assembly having cognizance of
42 matters relating to insurance that identifies the effect of health
43 insurance mandates under chapter 700c of the general statutes on
44 health care premiums paid by private sector employers, (4) develop
45 incentives to encourage individuals to use health insurance
46 responsibly, (5) develop a proposed plan and timetable for the
47 implementation of state-wide electronic prescribing, computerized
48 physician order entry in every hospital, and a uniform electronic
49 medical record system that will improve the quality of health care in
50 the state, (6) plan for the implementation of a pharmaceutical

51 purchasing pool to be administered by a third-party administrator to
52 cover all public employees and public programs, (7) establish the
53 Connecticut Health Quality Partnership under section 31 of this act, (8)
54 perform the duties as required under section 36 of this act, and (9) not
55 later than January 1, 2009, and annually thereafter, make
56 recommendations to the General Assembly concerning the
57 implementation of the Connecticut Healthy Steps Program and
58 improvements to the health care system, including cost controls.

59 (d) The commission shall meet as often as necessary to complete its
60 work, but not less than quarterly each year. The commission, within
61 available appropriations, may hire consultants to provide assistance
62 with its responsibilities.

63 Sec. 3. (NEW) (*Effective July 1, 2007*) (a) The Insurance Department,
64 in consultation with the Health Care Reform Commission, shall
65 develop and issue a request for proposals in accordance with the
66 provisions of sections 4-212 to 4-219, inclusive, of the general statutes
67 and award a five-year contract to administer the Connecticut
68 Connector. Such contract shall be awarded to a private nonprofit
69 organization which shall serve as a health insurance purchasing pool,
70 through which previously uninsured individuals and uninsured
71 employers may purchase health plans.

72 (b) Such organization administering the Connecticut Connector
73 shall meet with the Health Care Reform Commission in accordance
74 with a schedule the commission determines to be appropriate.

75 (c) Such organization shall perform the following duties:

76 (1) Solicit insurers to make products available for sale through the
77 Connecticut Connector;

78 (2) Review the products for compliance with benefit and other
79 standards as established by the Health Care Reform Commission;

80 (3) Publish easy to understand materials for prospective purchasers,
81 comparing the costs and benefits of all plans and providing counseling

82 to assist in plan selection;

83 (4) Screen applicants consisting of individuals and employers for
84 eligibility to purchase through the pool;

85 (5) Work with the insurers selling products through the Connecticut
86 Connector to develop a uniform tool for collecting necessary applicant
87 or enrollee data for any appropriate underwriting, enrollment and
88 other purposes;

89 (6) Collect premium contributions from employers and individuals,
90 as well as subsidies from the state, and remit them to the enrollees'
91 health plans;

92 (7) Collect fees from each insurer that sells products through the
93 Connecticut Connector, in accordance with rules adopted by the
94 Health Care Reform Commission, to support the costs of
95 administration;

96 (8) Notify insureds when their premiums are late and disenroll
97 them or levy late penalties as appropriate;

98 (9) Provide notices as required under the Health Insurance
99 Portability and Accountability Act of 1996, (P.L. 104-191) (HIPAA), as
100 from time to time amended, regarding creditable coverage;

101 (10) Market the health plans available though the Connecticut
102 Connector to potential purchasers of the health plans;

103 (11) Administer the programs in accordance with sections 6 to 8,
104 inclusive, of this act;

105 (12) Receive moneys from the Comptroller and make payments to
106 eligible individuals and employers in accordance with sections 10 and
107 11 of this act;

108 (13) Not later than July 1, 2009, and annually thereafter, provide
109 data and reports to the Health Care Reform Commission and the
110 General Assembly, which shall include, but not be limited to (A) the

111 number and demographics of previously uninsured persons covered
112 through the Connecticut Connector by type of policy, (B) the per capita
113 administrative costs of the Connecticut Connector, (C) any
114 recommendations for improving service, health insurance policy
115 offerings and costs, and (D) any other information as required by said
116 commission.

117 Sec. 4. (NEW) (*Effective July 1, 2007*) (a) The organization that
118 administers the Connecticut Connector shall make available to each
119 applicant seeking enrollment in the program a choice of three health
120 insurance plan types as follows: (1) An affordable health care plan
121 established in accordance with standards established by the Health
122 Care Reform Commission; (2) a comprehensive health care plan
123 currently available from insurers at the option of such insurers; and (3)
124 a health savings account plus high deductible plan currently available
125 from insurers at the option of such insurers.

126 (b) The affordable health care plan shall include, but not be limited
127 to:

128 (1) Coverage of any physician, clinic, ambulatory surgery,
129 laboratory and diagnostic services, in-patient and out-patient hospital
130 care and prescription drugs that are medically necessary for physical
131 or mental health;

132 (2) Coinsurance that shall reflect family income brackets;

133 (3) A copayment not to exceed seventy-five dollars for inappropriate
134 use of the emergency department of a hospital;

135 (4) A lifetime benefits maximum in the amount of five hundred
136 thousand dollars, contingent upon the availability of an excess cost
137 reinsurance program through the Department of Social Services for
138 which an individual or family would become eligible without
139 spending down all of their resources upon exhaustion of their
140 insurance benefit; and

141 (5) A minimum loss ratio of not less than eighty-five per cent over

142 any three-year moving average period.

143 (c) Each health care plan offered shall:

144 (1) Be community-rated based on the individual's age, sex, county of
145 residence and tobacco use; and

146 (2) Have a medical loss ratio of at least eighty-five per cent.

147 (d) Coverage under each of the health care plans shall be deemed to
148 be creditable coverage, as defined in 42 USC 300gg(c) and shall
149 preclude any exclusions for preexisting conditions in any subsequent
150 health care plan an individual may obtain.

151 (e) Each health care plan offered may elect not to cover the
152 preexisting conditions of any individual who has been uninsured for a
153 period exceeding twelve months.

154 (f) Any employer that purchases coverage through the program
155 may offer its employees any of the plans described in subsection (a) of
156 this section.

157 Sec. 5. (NEW) (*Effective July 1, 2007*) (a) An application by an
158 individual to purchase coverage through the Connecticut Connector
159 may be approved in cases in which an individual has no access to
160 employer-sponsored coverage under which the employer pays a
161 minimum of fifty per cent of the cost of such coverage for an
162 individual and their dependents and an individual has been:

163 (1) Uninsured for a period of at least six months; or

164 (2) Uninsured for a period of less than six months due to the
165 occurrence of a major life event that has resulted in such uninsured
166 status, including, but not limited to:

167 (A) Loss of coverage through the employer, due to termination of
168 employment;

169 (B) Death of, or abandonment by, a family member who previously

170 provided coverage;

171 (C) Loss of dependent coverage due to spouse attaining the age of
172 sixty-five years and becoming eligible for Medicare;

173 (D) Disqualification as a dependent under a group comprehensive
174 health care plan;

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

178 (F) Extreme economic hardship on the part of either the employee or
179 the employer, as determined by the organization that administers the
180 Connecticut Connector; and

181 (G) Any other events that may be specified by the Health Care
182 Reform Commission.

183 (b) An application by an employer to purchase coverage through
184 the pool may be approved if such employer:

185 (1) Has fifty or fewer employees;

186 (2) Has not offered a comprehensive health insurance plan to any
187 employee for a period of at least six months; and

188 (3) Will contribute a minimum of seventy per cent of the cost of such
189 coverage for an employee and a minimum of fifty per cent of the cost
190 of dependent coverage for any dependent of such employee.

191 Sec. 6. (NEW) (*Effective July 1, 2007*) (a) For purposes of this section:

192 (1) "Employer" means any person, firm, business, educational
193 institution, nonprofit agency, corporation, limited liability company or
194 any other entity which, on at least fifty per cent of its working days
195 during the preceding twelve months, employed not more than fifty
196 eligible employees, the majority of whom were employed within the
197 state of Connecticut, but shall not include the state or any political

198 subdivision of the state;

199 (2) "Full-time employee" means any person employed by an
200 employer for thirty hours or more a week in a full-time position; and

201 (3) "Part-time employee" means any person employed by an
202 employer for less than thirty hours a week in a part-time position.

203 (b) There is hereby established a tax credit to assist employers with
204 providing health insurance to their employees to achieve the goal of
205 ensuring greater access to health insurance for residents of this state.
206 Any employer that elects to claim such tax credit shall submit a copy of
207 such employer's health insurance plan to the Connecticut Connector. If
208 said Connecticut Connector certifies that such plan meets or exceeds
209 the standards for the affordable health care plan established pursuant
210 to section 2 of this act, the Connecticut Connector shall issue a
211 certificate indicating such fact.

212 (c) (1) There shall be allowed a credit against the tax imposed under
213 chapter 208 and chapter 213a of the general statutes on any corporation
214 or entity subject to either tax, provided such employer (A) has
215 obtained a certificate from the Connecticut Connector in accordance
216 with this section, and (B) pays at least seventy per cent of the cost of an
217 employee's benefits and fifty per cent of the cost of dependents'
218 benefits for full-time employees.

219 (2) For employers offering such coverage to all full-time employees
220 but not to all part-time employees, the credit shall be in an amount
221 equal to twenty per cent of the cost of providing health care benefits,
222 provided such amount shall not exceed eight hundred dollars per
223 employee per year in the case of a policy covering an individual
224 employee, one thousand six hundred dollars per employee per year in
225 the case of a policy covering an employee and only one other
226 individual, or two thousand four hundred dollars per employee per
227 year in the case of a policy covering an employee and the family of
228 such employee.

229 (3) For employers offering such coverage to all full-time and part-
230 time employees, the credit shall be in an amount equal to twenty-five
231 per cent of the cost of providing health care benefits, provided such
232 amount shall not exceed one thousand per employee per year in the
233 case of a policy covering an individual employee, two thousand
234 dollars per employee per year in the case of a policy covering an
235 employee and only one other individual, or three thousand dollars per
236 employee per year in the case of a policy covering an employee and
237 the family of such employee.

238 (4) In the event the employer owes less than the value of the credit
239 allowed under this subsection, the employer shall be entitled to a
240 refund from the state in an amount equal to the amount of the unused
241 credit.

242 (d) An employer qualifying under subsection (c) of this section that
243 is a limited liability company, limited liability partnership, limited
244 partnership or S corporation, as defined in section 12-284b of the
245 general statutes, may distribute a credit to its members and such
246 members shall be eligible to use such credit against the tax imposed
247 under chapter 229 of the general statutes. The total credit that may be
248 distributed shall not be greater than the following:

249 (1) For employers offering such coverage to all full-time employees
250 but not part-time employees, the credit shall be in an amount equal to
251 twenty per cent of the cost of providing health benefits, provided such
252 amount shall not exceed eight hundred dollars per employee per year
253 in the case of a policy covering an individual employee, one thousand
254 six hundred dollars per employee per year in the case of a policy
255 covering an employee and only one other individual, or two thousand
256 four hundred dollars per employee per year in the case of a policy
257 covering the employee and the family of such employee.

258 (2) For employers offering such coverage to all full-time and part-
259 time employees, the credit shall be in an amount equal to twenty-five
260 per cent of the cost of providing health benefits, provided such amount
261 shall not exceed one thousand dollars per employee per year in the

262 case of a policy covering an individual employee, two thousand
263 dollars per employee per year in the case of a policy covering an
264 employee and only one other individual, or three thousand dollars per
265 employee per year in the case of a policy covering an employee and
266 the family of such employee.

267 (e) In the event the individual claiming a credit under this section
268 owes less than the value of the credit allowed under this section, the
269 individual shall be entitled to a refund from the state in an amount
270 equal to the amount of the unused credit.

271 (f) The dollar amount of the credits in subsections (c) and (d) of this
272 section shall be annually indexed to the consumer price index for
273 medical care.

274 Sec. 7. (NEW) (*Effective July 1, 2007*) (a) For purposes of this section:

275 (1) "Employer" means any person, firm, business, educational
276 institution, nonprofit agency, corporation, limited liability company or
277 any other entity which, on at least fifty per cent of its working days
278 during the preceding twelve months, employed not more than fifty
279 eligible employees, the majority of whom were employed within the
280 state of Connecticut, but shall not include the state or any political
281 subdivision of the state;

282 (2) "Full-time employee" means any person employed by an
283 employer for thirty hours or more a week in a full-time position; and

284 (3) "Part-time employee" means any person employed by an
285 employer for less than thirty hours a week in a part-time position.

286 (b) There is hereby established a tax credit to assist employers with
287 providing health insurance to their employees to achieve the goal of
288 ensuring greater access to health insurance for residents of this state.
289 Any employer that elects to claim such tax credit shall submit a copy of
290 such employer's health insurance plan to the Connecticut Connector. If
291 said Connecticut Connector certifies that such plan meets or exceeds
292 the standards for the comprehensive health care plan established

293 pursuant to section 2 of this act, the Connecticut Connector shall issue
294 a certificate indicating such fact.

295 (c) (1) There shall be allowed a credit against the tax imposed under
296 chapter 208 and chapter 213a of the general statutes on any corporation
297 or entity subject to either tax, provided such employer has (A)
298 obtained a certificate from the Connecticut Connector in accordance
299 with this section, and (B) pays at least seventy per cent of the cost of an
300 employee's benefits and fifty per cent of the cost of dependents'
301 benefits for full-time employees.

302 (2) For employers offering such coverage to all full-time employees
303 but not to all part-time employees, the credit shall be in an amount
304 equal to thirty per cent of the cost of providing health care benefits,
305 provided such amount shall not exceed one thousand two hundred
306 dollars per employee per year in the case of a policy covering an
307 individual employee, two thousand four hundred dollars per
308 employee per year in the case of a policy covering an employee and
309 only one other individual, or three thousand six hundred dollars per
310 employee per year in the case of a policy covering an employee and
311 the family of such employee.

312 (3) For employers offering such coverage to all full-time and all
313 part-time employees, the credit shall be in an amount equal to thirty-
314 five per cent of the cost of providing health care benefits, provided
315 such amount shall not exceed one thousand four hundred dollars per
316 employee per year in the case of a policy covering an individual
317 employee, two thousand eight hundred dollars per employee per year
318 in the case of a policy covering an employee and only one other
319 individual, or four thousand two hundred dollars per year in the case
320 of a policy covering an employee and the family of such employee.

321 (4) In the event the employer owes less than the value of the credit
322 allowed under this subsection, the employer shall be entitled to a
323 refund from the state in an amount equal to the amount of the unused
324 credit.

325 (d) An employer qualifying under subsection (c) of this section that
326 is a limited liability company, limited liability partnership, limited
327 partnership or S corporation, as defined in section 12-284b of the
328 general statutes, may distribute a credit to its members and such
329 members shall be eligible to use such credit against the tax imposed
330 under chapter 229 of the general statutes. The total credit that may be
331 distributed shall not be greater than the following:

332 (1) For employers offering such coverage to all full-time employees
333 but not to part-time employees, the credit shall be in an amount equal
334 to thirty per cent of the cost of providing health benefits, provided
335 such amount shall not exceed one thousand two hundred dollars per
336 employee per year in the case of a policy covering an individual
337 employee, two thousand four hundred dollars per employee per year
338 in the case of a policy covering an employee and only one other
339 individual, or three thousand six hundred dollars per employee per
340 year in the case of a policy covering an employee and the family of
341 such employee.

342 (2) For employers offering such coverage to all full-time and all
343 part-time employees, the credit shall be in an amount equal to thirty-
344 five per cent of the cost of providing health care to a part-time
345 employee, provided such amount shall not exceed one thousand four
346 hundred fifty dollars per employee per year in the case of a policy
347 covering an individual employee, two thousand eight hundred dollars
348 per employee per year in the case of a policy covering an employee
349 and only one other individual, or four thousand two hundred dollars
350 per employee per year in the case of a policy covering an employee
351 and the family of such employee.

352 (e) In the event the individual claiming a credit under this section
353 owes less than the value of the credit allowed under this section, the
354 individual shall be entitled to a refund from the state in an amount
355 equal to the amount of the unused credit.

356 (f) The dollar amount of credits in subsections (c) and (d) of this
357 section shall be annually indexed to the consumer price index for

358 medical care.

359 Sec. 8. (NEW) (*Effective July 1, 2007*) (a) For purposes of this section:

360 (1) "Employer" means any person, firm, business, educational
361 institution, nonprofit agency, corporation, limited liability company or
362 any other entity which, on at least fifty per cent of its working days
363 during the preceding twelve months, employed not more than fifty
364 eligible employees, the majority of whom were employed within the
365 state of Connecticut, but shall not include the state or any political
366 subdivision of the state;

367 (2) "Full-time employee" means any person employed by an
368 employer for thirty hours or more a week in a full-time position; and

369 (3) "Part-time employee" means any person employed by an
370 employer for less than thirty hours a week in a part-time position.

371 (b) There is hereby established a tax credit to assist employers with
372 providing health insurance to their employees to achieve the goal of
373 ensuring greater access to health insurance for residents of this state.
374 Any eligible employer that elects to claim such tax credit shall submit a
375 copy of such employer's health insurance plan to the Connecticut
376 Connector. If said Connecticut Connector certifies that such plan meets
377 or exceeds the minimum benefit plan provided to state employees
378 pursuant to the State Employees' Bargaining Agent Coalition (SEBAC)
379 agreement, the Connecticut Connector shall issue a certificate
380 indicating such fact.

381 (c) (1) There shall be allowed a credit against the tax imposed under
382 chapter 208 and chapter 213a of the general statutes on any corporation
383 or entity subject to either tax, provided such employer (A) has
384 obtained a certificate from the Connecticut Connector in accordance
385 with this section, and (B) pays at least seventy per cent of the cost of an
386 employee's benefits and fifty per cent of the cost of dependents'
387 benefits for full-time employees.

388 (2) For employers offering such coverage to all full-time employees

389 but not to all part-time employees, the credit shall be in an amount
390 equal to forty per cent of the cost of providing health care benefits,
391 provided such amount shall not exceed one thousand six hundred
392 dollars per employee per year in the case of a policy covering an
393 individual employee, three thousand two hundred dollars per
394 employee per year in the case of a policy covering an employee and
395 only one other individual, or four thousand eight hundred dollars per
396 employee per year in the case of a policy covering an employee and
397 the family of such employee.

398 (3) For employers offering such coverage to all full-time and all
399 part-time employees, the credit shall be in an amount equal to forty-
400 five per cent of the cost of providing health care benefits provided such
401 amount shall not exceed one thousand eight hundred dollars per
402 employee per year in the case of a policy covering an individual
403 employee, three thousand six hundred dollars per employee per year
404 in the case of a policy covering an employee and only one other
405 individual, or five thousand four hundred dollars per part-time
406 employee in the case of a policy covering a family.

407 (4) In the event the employer owes less than the value of the credit
408 allowed under this subsection, the employer shall be entitled to a
409 refund from the state in an amount equal to the amount of the unused
410 tax credit.

411 (d) An employer qualifying under subsection (c) of this section that
412 is a limited liability company, limited liability partnership, limited
413 partnership or S corporation, as defined in section 12-284b of the
414 general statutes, may distribute a credit to its members and such
415 members shall be eligible to use such credit against the tax imposed
416 under chapter 229 of the general statutes. The total credit that may be
417 distributed shall not be greater than the following:

418 (1) For employers offering such coverage to all full-time employees
419 but not to all part-time employees, an amount equal to forty per cent of
420 the cost of providing health care benefits, provided such amount shall
421 not exceed one thousand six hundred dollars per employee per year in

422 the case of a policy covering an individual employee, three thousand
423 two hundred dollars per employee per year in the case of a policy
424 covering an employee and only one other individual, or four thousand
425 eight hundred dollars per employee per year in the case of a policy
426 covering an employee and the family of such employee.

427 (2) For employers offering such coverage to all full-time and all
428 part-time employees, an amount equal to forty-five per cent of the cost
429 of providing health care benefits, provided such amount shall not
430 exceed one thousand eight hundred dollars per employee per year in
431 the case of a policy covering an individual employee, three thousand
432 six hundred dollars per employee per year in the case of a policy
433 covering an employee and only one other individual, or five thousand
434 four hundred dollars per employee per year in the case of a policy
435 covering an employee and the family of such employee.

436 (e) In the event the individual claiming a credit under this section
437 owes less than the value of the credit allowed under this section, the
438 individual shall be entitled to a refund from the state in an amount
439 equal to the amount of the unused credit.

440 (f) The dollar amount of credits in subsections (c) and (d) of this
441 section shall be annually indexed to the consumer price index for
442 medical care.

443 Sec. 9. (NEW) (*Effective July 1, 2007*) (a) The Connecticut Connector
444 shall, not later than thirty days after receipt of all relevant information
445 provided by an employer, determine whether to certify that an
446 employer is eligible for a tax credit pursuant to section 6, 7 or 8 of this
447 act.

448 (b) Said Connecticut Connector shall provide information to
449 employers seeking assistance with obtaining certification pursuant to
450 this section.

451 Sec. 10. (NEW) (*Effective July 1, 2007*) (a) There is established the
452 health savings account incentive program. To be eligible for payment

453 pursuant to this section, an individual's family income may not exceed
454 four hundred per cent of the federal poverty level. The Connecticut
455 Connector shall annually contribute to the health savings account of
456 any individual who resides in the state and who has a health savings
457 account and high deductible health plan pursuant to section 223 of the
458 Internal Revenue Code of 1986, or any subsequent corresponding
459 internal revenue code of the United States, as from time to time
460 amended, an amount determined by a sliding scale as follows:

461 (1) For a family income equal to or less than two hundred per cent
462 of the federal poverty level, five hundred dollars for an individual who
463 has contributed or received contributions of at least two thousand five
464 hundred dollars in his or her health savings account in the previous
465 year, one thousand dollars for a family of two who has contributed or
466 received contributions of at least three thousand seven hundred fifty
467 dollars in their health savings account in the previous year, or one
468 thousand five hundred dollars for a family of three or more who has
469 contributed or received contributions of at least five thousand dollars
470 in their health savings account in the previous year.

471 (2) For a family income greater than two hundred per cent but less
472 than three hundred per cent of the federal poverty level, four hundred
473 dollars for an individual who has contributed or received
474 contributions of at least two thousand five hundred dollars in his or
475 her health savings account in the previous year, eight hundred dollars
476 for a family of two who has contributed or received contributions of at
477 least three thousand seven hundred fifty dollars in their health savings
478 account in the previous year, or one thousand two hundred dollars for
479 a family of three or more who has contributed or received
480 contributions of at least five thousand dollars in their health savings
481 account in the previous year.

482 (3) For a family income equal to or greater than three hundred per
483 cent but less than four hundred per cent of the federal poverty level,
484 three hundred dollars for an individual who has contributed or
485 received contributions of at least two thousand five hundred dollars in

486 his or her health savings account in the previous year, six hundred
487 dollars for a family of two who has contributed or received
488 contributions of at least three thousand seven hundred fifty dollars in
489 their health savings account in the previous year, or nine hundred
490 dollars for a family of three or more who has contributed or received
491 contributions of at least five thousand dollars in their health savings
492 account in the previous year.

493 (b) The amounts specified in subdivisions (2) and (3) of subsection
494 (a) of this section shall be annually indexed to the consumer price
495 index for medical care.

496 (c) The Connecticut Connector shall make payments, in accordance
497 with this section, by January thirtieth of any year for health savings
498 account contributions in the prior calendar year. The Connecticut
499 Connector shall establish procedures by which individuals may claim
500 payment pursuant to this section.

501 Sec. 11. (NEW) (*Effective July 1, 2007*) (a) There is established the
502 premium subsidy program. To be eligible for payment pursuant to this
503 section, an individual (1) shall not have family income exceeding four
504 hundred per cent of the federal poverty level, (2) shall not individually
505 or as part of a family own a health savings account pursuant to section
506 223 of the Internal Revenue Code of 1986, or any subsequent
507 corresponding internal revenue code of the United States, as from time
508 to time amended, and (3) shall have health care coverage under an
509 employer-sponsored plan for which the employee pays at least five
510 hundred dollars in premiums annually to the employee's employer if
511 single and at least one thousand dollars in premiums annually to the
512 employee's employer if the employee is covered by a family plan or
513 has a nonemployer-based plan purchased through the individual
514 market or the Connecticut Connector. The Connecticut Connector shall
515 quarterly reimburse an individual who is eligible pursuant to this
516 section for premiums paid in the preceding quarter as follows:

517 (A) For a family with income equal to or less than two hundred per
518 cent of the federal poverty level, eighty per cent of their share of the

519 premium, not to exceed one hundred twenty-five dollars per quarter
520 for an individual, two hundred fifty dollars per quarter for an
521 individual plus one dependent, or three hundred seventy-five dollars
522 per quarter for a family.

523 (B) For a family with income greater than two hundred per cent but
524 less than three hundred per cent of the federal poverty level, sixty per
525 cent of their share of the premium, not to exceed one hundred dollars
526 per quarter for an individual, two hundred dollars per quarter for an
527 individual plus one dependent, or three hundred dollars per quarter
528 for a family.

529 (C) For a family with income greater than three hundred per cent
530 but less than four hundred per cent of the federal poverty level, forty
531 per cent of their share of the premium, not to exceed seventy-five
532 dollars per quarter for an individual, one hundred fifty dollars per
533 quarter for an individual plus one dependent, or two hundred twenty-
534 five dollars per quarter for a family.

535 (b) The Connecticut Connector shall establish procedures by which
536 individuals may claim payment pursuant to this section.

537 Sec. 12. (NEW) (*Effective July 1, 2007*) The Commissioner of Social
538 Services shall seek a federal waiver for the purpose of (1) obtaining any
539 available federal reimbursement for state expenditures related to the
540 health savings account incentive program established under section 10
541 of this act and the subsidized premium program established under
542 section 11 of this act, and (2) establishing a state excess cost
543 reinsurance program for enrollees in the Connecticut Connector's
544 affordable health care plan to allow such enrollees to obtain coverage
545 through the Medicaid program once their insurance benefits are
546 exhausted without having to spend down their assets.

547 Sec. 13. (NEW) (*Effective July 1, 2007*) No employer in this state may
548 offer health benefit plans of lesser value to lower-paid employees than
549 to higher-paid employees.

550 Sec. 14. (NEW) (*Effective July 1, 2007*) The Commissioner of Social
551 Services shall develop a plan to implement a system of primary care
552 case management for the delivery of health care services to all or a
553 substantial subset of the aged, blind and disabled Medicaid
554 beneficiaries. Said commissioner may contract with an administrative
555 services organization to effectuate the implementation of such primary
556 care case management system. Such plan shall include programs to
557 improve coordination of and access to medical services, chronic
558 disease management programs, predictive modeling to identify high
559 risk, complex and high-cost Medicaid beneficiaries and to provide
560 them with intensive care coordination.

561 Sec. 15. (NEW) (*Effective July 1, 2007*) On and after January 1, 2008,
562 the Commissioner of Social Services shall allow aged, blind or disabled
563 Medicaid beneficiaries to voluntarily enroll in the managed care plans
564 available to HUSKY Plan, Part A and HUSKY Plan, Part B
565 beneficiaries.

566 Sec. 16. Section 17b-267 of the general statutes is repealed and the
567 following is substituted in lieu thereof (*Effective July 1, 2007*):

568 (a) If any group or association of providers of medical assistance
569 services wishes to have payments as provided for under sections 17b-
570 260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to
571 17b-361, inclusive, to such providers made through a national, state or
572 other public or private agency or organization and nominates such
573 agency or organization for this purpose, the Commissioner of Social
574 Services is authorized to enter into an agreement with such agency or
575 organization providing for the determination by such agency or
576 organization, subject to such review by the Commissioner of Social
577 Services as may be provided for by the agreement, of the payments
578 required to be made to such providers at the rates set by the hospital
579 cost commission, and for the making of such payments by such agency
580 or organization to such providers. Such agreement may also include
581 provision for the agency or organization to do all or any part of the
582 following: With respect to the providers of services which are to

583 receive payments through it, (1) to serve as a center for, and to
584 communicate to providers, any information or instructions furnished
585 to it by the Commissioner of Social Services, and to serve as a channel
586 of communication from providers to the Commissioner of Social
587 Services; (2) to make such audits of the records of providers as may be
588 necessary to insure that proper payments are made under this section;
589 and (3) to perform such other functions as are necessary to carry out
590 the provisions of sections 17b-267 to 17b-271, inclusive.

591 (b) The Commissioner of Social Services shall not enter into an
592 agreement with any agency or organization under subsection (a) of
593 this section unless (1) he finds (A) that to do so is consistent with the
594 effective and efficient administration of the medical assistance
595 program, and (B) that such agency or organization is willing and able
596 to assist the providers to which payments are made through it in the
597 application of safeguards against unnecessary utilization of services
598 furnished by them to individuals entitled to hospital insurance benefits
599 under section 17b-261 and the agreement provides for such assistance,
600 and (2) such agency or organization agrees to furnish to the
601 Commissioner of Social Services such of the information acquired by it
602 in carrying out its agreement under sections 17b-267 to 17b-271,
603 inclusive, as the Commissioner of Social Services may find necessary in
604 performing his functions under said sections.

605 (c) An agreement with any agency or organization under subsection
606 (a) of this section may contain such terms and conditions as the
607 Commissioner of Social Services finds necessary or appropriate, may
608 provide for advances of funds to the agency or organization for the
609 making of payments by it under said subsection (a), and shall provide
610 for payment by the Commissioner of Social Services of so much of the
611 cost of administration of the agency or organization as is determined
612 by the Commissioner of Social Services to be necessary and proper for
613 carrying out the functions covered by the agreement.

614 (d) On or after July 1, 2007, each managed care plan that enters into,
615 renews or amends a contract with the Department of Social Services

616 pursuant to this section shall limit its administrative costs to ten per
617 cent of payments made pursuant to such contracts. The Commissioner
618 of Social Services shall implement policies and procedures to effectuate
619 the purposes of this subsection while in the process of adopting such
620 policies or procedures in regulation form, provided notice of intention
621 to adopt the regulations is printed in the Connecticut Law Journal not
622 later than twenty days after implementation of such policies and
623 procedures and any such policies and procedures shall be valid until
624 the time the regulations are effective. The Commissioner of Social
625 Services may define administrative costs to exclude disease
626 management or other value-added clinical programs administered by
627 the managed care plans, but not to exclude utilization management,
628 claims, member services or other nonclinical functions.

629 Sec. 17. (NEW) (*Effective July 1, 2007*) (a) On July 1, 2007, the
630 Commissioner of Social Services shall increase the fee-for-service
631 Medicaid reimbursement rates for (1) dental services by sixty per cent,
632 (2) physician services to a level equivalent to at least eighty per cent of
633 Medicare rates in aggregate, and (3) hospital services to a level
634 equivalent to at least ninety per cent of Medicare rates in aggregate.
635 The rates of reimbursement to be paid to dentists under the fee-for-
636 service program shall be annually increased to reflect increases in the
637 consumer price index for medical care. The rates of reimbursement to
638 be paid to physicians and hospitals shall be annually increased to
639 remain at such percentage of Medicare rates.

640 (b) On July 1, 2007, the Commissioner of Social Services shall amend
641 each contract with a managed care plan entered into pursuant to
642 section 17b-266 of the general statutes, upon renewal, to require each
643 managed care plan to increase reimbursement to dentists, physicians,
644 and hospitals to at least the same levels specified in subsection (a) of
645 this section.

646 Sec. 18. Section 17b-297 of the general statutes is repealed and the
647 following is substituted in lieu thereof (*Effective July 1, 2007*):

648 (a) The commissioner, in consultation with the Children's Health

649 Council, the Medicaid Managed Care Council and Infoline of
650 Connecticut, shall develop mechanisms for outreach for the HUSKY
651 Plan, Part A and Part B, including, but not limited to, development of
652 mail-in applications and appropriate outreach materials through the
653 Department of Revenue Services, the Labor Department, the
654 Department of Social Services, the Department of Public Health, the
655 Department of Children and Families and the Office of Protection and
656 Advocacy for Persons with Disabilities.

657 (b) The commissioner shall include in such outreach efforts
658 information on the Medicaid program for the purpose of maximizing
659 enrollment of eligible children and the use of federal funds.

660 (c) The commissioner shall, within available appropriations,
661 contract with severe need schools and community-based organizations
662 for purposes of public education, outreach and recruitment of eligible
663 children, including the distribution of applications and information
664 regarding enrollment in the HUSKY Plan, Part A and Part B. In
665 awarding such contracts, the commissioner shall consider the
666 marketing, outreach and recruitment efforts of organizations. For the
667 purposes of this subsection, (1) "community-based organizations" shall
668 include, but not be limited to, day care centers, schools, school-based
669 health clinics, community-based diagnostic and treatment centers and
670 hospitals, and (2) "severe need school" means a school in which forty
671 per cent or more of the lunches served are served to students who are
672 eligible for free or reduced price lunches.

673 (d) All outreach materials shall be approved by the commissioner
674 pursuant to Subtitle J of Public Law 105-33.

675 (e) Not later than October 1, 2007, the commissioner shall award
676 fifty grants in an amount not to exceed ten thousand dollars to
677 community-based organizations for the purposes of public education,
678 outreach and recruitment of eligible children, including the
679 distribution of applications and information regarding enrollment in
680 the HUSKY Plan, Part A and Part B.

681 [(e)] (f) Not later than January 1, 1999, and annually thereafter, the
682 commissioner shall submit a report to the Governor and the General
683 Assembly on the implementation of and the results of the community-
684 based outreach program specified in subsections (a) to (c), inclusive, of
685 this section.

686 Sec. 19. Subsection (a) of section 17b-261 of the general statutes is
687 repealed and the following is substituted in lieu thereof (*Effective July*
688 *1, 2007*):

689 (a) Medical assistance shall be provided for any otherwise eligible
690 person whose income, including any available support from legally
691 liable relatives and the income of the person's spouse or dependent
692 child, is not more than one hundred forty-three per cent, pending
693 approval of a federal waiver applied for pursuant to subsection (d) of
694 this section, of the benefit amount paid to a person with no income
695 under the temporary family assistance program in the appropriate
696 region of residence and if such person is an institutionalized
697 individual as defined in Section 1917(c) of the Social Security Act, 42
698 USC 1396p(c), and has not made an assignment or transfer or other
699 disposition of property for less than fair market value for the purpose
700 of establishing eligibility for benefits or assistance under this section.
701 Any such disposition shall be treated in accordance with Section
702 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
703 property made on behalf of an applicant or recipient or the spouse of
704 an applicant or recipient by a guardian, conservator, person
705 authorized to make such disposition pursuant to a power of attorney
706 or other person so authorized by law shall be attributed to such
707 applicant, recipient or spouse. A disposition of property ordered by a
708 court shall be evaluated in accordance with the standards applied to
709 any other such disposition for the purpose of determining eligibility.
710 The commissioner shall establish the standards for eligibility for
711 medical assistance at one hundred forty-three per cent of the benefit
712 amount paid to a family unit of equal size with no income under the
713 temporary family assistance program in the appropriate region of
714 residence, pending federal approval, except that the medical assistance

715 program shall provide coverage to persons under the age of nineteen
716 up to one hundred eighty-five per cent of the federal poverty level
717 without an asset limit. Said medical assistance program shall also
718 provide coverage to persons under the age of nineteen and their
719 parents and needy caretaker relatives who qualify for coverage under
720 Section 1931 of the Social Security Act with family income up to one
721 hundred [fifty] eighty-five per cent of the federal poverty level without
722 an asset limit, upon the request of such a person or upon a
723 redetermination of eligibility. Such levels shall be based on the
724 regional differences in such benefit amount, if applicable, unless such
725 levels based on regional differences are not in conformance with
726 federal law. Any income in excess of the applicable amounts shall be
727 applied as may be required by said federal law, and assistance shall be
728 granted for the balance of the cost of authorized medical assistance. All
729 contracts entered into on and after July 1, 1997, pursuant to this section
730 shall include provisions for collaboration of managed care
731 organizations with the Nurturing Families Network established
732 pursuant to section 17a-56. The Commissioner of Social Services shall
733 provide applicants for assistance under this section, at the time of
734 application, with a written statement advising them of (1) the effect of
735 an assignment or transfer or other disposition of property on eligibility
736 for benefits or assistance, and (2) the availability of, and eligibility for,
737 services provided by the Nurturing Families Network established
738 pursuant to section 17a-56.

739 Sec. 20. Section 17b-261 of the general statutes is amended by
740 adding subsection (k) as follows (*Effective July 1, 2007*):

741 (NEW) (k) The Commissioner of Social Services, pursuant to 42 USC
742 1396a(r)(2), shall file an amendment to the Medicaid state plan to allow
743 the commissioner, when making Medicaid eligibility determinations,
744 to raise the medically needy income limit for persons who are aged,
745 blind or disabled to an amount not to exceed one hundred fifty per
746 cent of the federal poverty level.

747 Sec. 21. Section 17b-292 of the general statutes is repealed and the

748 following is substituted in lieu thereof (*Effective July 1, 2007*):

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

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

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

760 (d) A child or adult who has been determined to be eligible for
761 benefits under either the HUSKY Plan, Part A or Part B shall remain
762 eligible for such plan for a period of twelve months from such child's
763 determination of eligibility unless the child attains the age of nineteen
764 or is no longer a resident of the state. During the twelve-month period
765 following the date that a child is determined eligible for the HUSKY
766 Plan, Part A or Part B, the family of such child shall comply with
767 federal requirements concerning the reporting of information to the
768 department, including, but not limited to, change of address
769 information.

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

774 [(e)] (f) A newborn child who otherwise meets the eligibility criteria
775 for the HUSKY Plan, Part B shall be eligible for benefits retroactive to
776 his date of birth, provided an application is filed on behalf of the child
777 [within] not later than thirty days [of] after such date. Any uninsured
778 child born in a hospital in this state or in an eligible border state

779 hospital shall be enrolled by an expedited process in the HUSKY Plan,
780 Part B provided (1) the child's family resides in this state, and (2) a
781 parent of such child authorizes enrollment in the program. The
782 commissioner shall pay any premium cost such family would
783 otherwise incur for the first two months of coverage to the managed
784 care organization selected by the family to provide coverage for such
785 child.

786 [(f)] (g) The commissioner shall implement presumptive eligibility
787 for children applying for Medicaid. Such presumptive eligibility
788 determinations shall be in accordance with applicable federal law and
789 regulations. The commissioner shall adopt regulations, in accordance
790 with chapter 54, to establish standards and procedures for the
791 designation of organizations as qualified entities to grant presumptive
792 eligibility. Qualified entities shall ensure that, at the time a
793 presumptive eligibility determination is made, a completed application
794 for Medicaid is submitted to the department for a full eligibility
795 determination. In establishing such standards and procedures, the
796 commissioner shall ensure the representation of state-wide and local
797 organizations that provide services to children of all ages in each
798 region of the state.

799 [(g)] (h) The commissioner shall enter into a contract with an entity
800 to be a single point of entry servicer for applicants and enrollees under
801 the HUSKY Plan, Part A and Part B. The servicer shall jointly market
802 both Part A and Part B together as the HUSKY Plan. Such servicer shall
803 develop and implement public information and outreach activities
804 with community programs. Such servicer shall electronically transmit
805 data with respect to enrollment and disenrollment in the HUSKY Plan,
806 Part B to the commissioner.

807 [(h)] (i) Upon the expiration of any contractual provisions entered
808 into pursuant to subsection [(g)] (h) of this section, the commissioner
809 shall develop a new contract for single point of entry services and
810 managed care enrollment brokerage services. The commissioner may
811 enter into one or more contractual arrangements for such services for a

812 contract period not to exceed seven years. Such contracts shall include
813 performance measures, including, but not limited to, specified time
814 limits for the processing of applications, parameters setting forth the
815 requirements for a completed and reviewable application and the
816 percentage of applications forwarded to the department in a complete
817 and timely fashion. Such contracts shall also include a process for
818 identifying and correcting noncompliance with established
819 performance measures, including sanctions applicable for instances of
820 continued noncompliance with performance measures.

821 [(i)] (j) The single point of entry servicer shall send an application
822 and supporting documents to the commissioner for determination of
823 eligibility of a child who resides in a household with a family income
824 of one hundred eighty-five per cent or less of the federal poverty level.
825 The servicer shall enroll eligible beneficiaries in the applicant's choice
826 of managed care plan. Upon enrollment in a managed care plan, an
827 eligible HUSKY Plan, Part A or Part B beneficiary shall remain
828 enrolled in such managed care plan for twelve months from the date of
829 such enrollment unless (1) an eligible beneficiary demonstrates good
830 cause to the satisfaction of the commissioner of the need to enroll in a
831 different managed care plan, or (2) the beneficiary no longer meets
832 program eligibility requirements.

833 [(j)] (k) Not more than twelve months after the determination of
834 eligibility for benefits under the HUSKY Plan, Part A and Part B and
835 annually thereafter, the commissioner or the servicer, as the case may
836 be, shall determine if the child continues to be eligible for the plan. The
837 commissioner or the servicer shall mail an application form to each
838 participant in the plan for the purposes of obtaining information to
839 make a determination on eligibility. To the extent permitted by federal
840 law, in determining eligibility for benefits under the HUSKY Plan, Part
841 A or Part B with respect to family income, the commissioner or the
842 servicer shall rely upon information provided in such form by the
843 participant unless the commissioner or the servicer has reason to
844 believe that such information is inaccurate or incomplete. The
845 Department of Social Services shall annually review a random sample

846 of cases to confirm that, based on the statistical sample, relying on such
847 information is not resulting in ineligible clients receiving benefits
848 under HUSKY Plan, Part A or Part B. The determination of eligibility
849 shall be coordinated with health plan open enrollment periods.

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

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

861 Sec. 22. Section 38a-567 of the general statutes is repealed and the
862 following is substituted in lieu thereof (*Effective July 1, 2007*):

863 Health insurance plans and insurance arrangements covering small
864 employers and insurers and producers marketing such plans and
865 arrangements shall be subject to the following provisions:

866 (1) (A) Any such plan or arrangement shall be renewable with
867 respect to all eligible employees or dependents at the option of the
868 small employer, policyholder or contract-holder, as the case may be,
869 except: (i) For nonpayment of the required premiums by the small
870 employer, policyholder or contract-holder; (ii) for fraud or
871 misrepresentation of the small employer, policyholder or
872 contractholder or, with respect to coverage of individual insured, the
873 insureds or their representatives; (iii) for noncompliance with plan or
874 arrangement provisions; (iv) when the number of insureds covered
875 under the plan or arrangement is less than the number of insureds or
876 percentage of insureds required by participation requirements under
877 the plan or arrangement; or (v) when the small employer, policyholder

878 or contractholder is no longer actively engaged in the business in
879 which it was engaged on the effective date of the plan or arrangement.

880 (B) Renewability of coverage may be effected by either continuing in
881 effect a plan or arrangement covering a small employer or by
882 substituting upon renewal for the prior plan or arrangement the plan
883 or arrangement then offered by the carrier that most closely
884 corresponds to the prior plan or arrangement and is available to other
885 small employers. Such substitution shall only be made under
886 conditions approved by the commissioner. A carrier may substitute a
887 plan or arrangement as stated above only if the carrier effects the same
888 substitution upon renewal for all small employers previously covered
889 under the particular plan or arrangement, unless otherwise approved
890 by the commissioner. The substitute plan or arrangement shall be
891 subject to the rating restrictions specified in this section on the same
892 basis as if no substitution had occurred, except for an adjustment
893 based on coverage differences.

894 (C) Notwithstanding the provisions of this subdivision, any such
895 plan or arrangement, or any coverage provided under such plan or
896 arrangement may be rescinded for fraud, material misrepresentation
897 or concealment by an applicant, employee, dependent or small
898 employer.

899 (D) Any individual who was not a late enrollee at the time of his or
900 her enrollment and whose coverage is subsequently rescinded shall be
901 allowed to reenroll as of a current date in such plan or arrangement
902 subject to any preexisting condition or other provisions applicable to
903 new enrollees without previous coverage. On and after the effective
904 date of such individual's reenrollment, the small employer carrier may
905 modify the premium rates charged to the small employer for the
906 balance of the current rating period and for future rating periods, to
907 the level determined by the carrier as applicable under the carrier's
908 established rating practices had full, accurate and timely underwriting
909 information been supplied when such individual initially enrolled in
910 the plan. The increase in premium rates allowed by this provision for

911 the balance of the current rating period shall not exceed twenty-five
912 per cent of the small employer's current premium rates. Any such
913 increase for the balance of said current rating period shall not be
914 subject to the rate limitation specified in subdivision (6) of this section.
915 The rate limitation specified in this section shall otherwise be fully
916 applicable for the current and future rating periods. The modification
917 of premium rates allowed by this subdivision shall cease to be
918 permitted for all plans and arrangements on the first rating period
919 commencing on or after July 1, 1995.

920 (2) Except in the case of a late enrollee who has failed to provide
921 evidence of insurability satisfactory to the insurer, the plan or
922 arrangement may not exclude any eligible employee or dependent
923 who would otherwise be covered under such plan or arrangement on
924 the basis of an actual or expected health condition of such person. No
925 plan or arrangement may exclude an eligible employee or eligible
926 dependent who, on the day prior to the initial effective date of the plan
927 or arrangement, was covered under the small employer's prior health
928 insurance plan or arrangement pursuant to workers' compensation,
929 continuation of benefits pursuant to federal extension requirements
930 established by the Consolidated Omnibus Budget Reconciliation Act of
931 1985 (P.L. 99-2721, as amended) or other applicable laws. The
932 employee or dependent must request coverage under the new plan or
933 arrangement on a timely basis and such coverage shall terminate in
934 accordance with the provisions of the applicable law.

935 (3) (A) For rating periods commencing on or after October 1, 1993,
936 and prior to July 1, 1994, the premium rates charged or offered for a
937 rating period for all plans and arrangements may not exceed one
938 hundred thirty-five per cent of the base premium rate for all plans or
939 arrangements.

940 (B) For rating periods commencing on or after July 1, 1994, and prior
941 to July 1, 1995, the premium rates charged or offered for a rating
942 period for all plans or arrangements may not exceed one hundred
943 twenty per cent of the base premium rate for such rating period. The

944 provisions of this subdivision shall not apply to any small employer
945 who employs more than twenty-five eligible employees.

946 (4) For rating periods commencing on or after October 1, 1993, and
947 prior to July 1, 1995, the percentage increase in the premium rate
948 charged to a small employer, who employs not more than twenty-five
949 eligible employees, for a new rating period may not exceed the sum of:

950 (A) The percentage change in the base premium rate measured from
951 the first day of the prior rating period to the first day of the new rating
952 period;

953 (B) An adjustment of the small employer's premium rates for the
954 prior rating period, and adjusted pro rata for rating periods of less
955 than one year, due to the claim experience, health status or duration of
956 coverage of the employees or dependents of the small employer, such
957 adjustment (i) not to exceed ten per cent annually for the rating
958 periods commencing on or after October 1, 1993, and prior to July 1,
959 1994, and (ii) not to exceed five per cent annually for the rating periods
960 commencing on or after July 1, 1994, and prior to July 1, 1995; and

961 (C) Any adjustments due to change in coverage or change in the
962 case characteristics of the small employer, as determined from the
963 small employer carrier's applicable rate manual.

964 (5) (A) With respect to plans or arrangements issued on or after July
965 1, [1995] 2008, the premium rates charged or offered to small
966 employers shall be established on the basis of a community rate,
967 adjusted to reflect one or more of the following classifications:

968 (i) Age, provided age brackets of less than five years shall not be
969 utilized;

970 (ii) Gender;

971 (iii) Geographic area, provided an area smaller than a county shall
972 not be utilized;

973 (iv) Industry, provided the rate factor associated with any industry
974 classification shall not vary from the arithmetic average of the highest
975 and lowest rate factors associated with all industry classifications by
976 greater than fifteen per cent of such average, and provided further, the
977 rate factors associated with any industry shall not be increased by
978 more than five per cent per year;

979 (v) Group size, provided the highest rate factor associated with
980 group size shall not vary from the lowest rate factor associated with
981 group size by a ratio of greater than 1.25 to 1.0;

982 (vi) Administrative cost savings resulting from the administration of
983 an association group plan or a plan written pursuant to section 5-259,
984 provided the savings reflect a reduction to the small employer carrier's
985 overall retention that is measurable and specifically realized on items
986 such as marketing, billing or claims paying functions taken on directly
987 by the plan administrator or association, except that such savings may
988 not reflect a reduction realized on commissions;

989 (vii) Savings resulting from a reduction in the profit of a carrier who
990 writes small business plans or arrangements for an association group
991 plan or a plan written pursuant to section 5-259 provided any loss in
992 overall revenue due to a reduction in profit is not shifted to other small
993 employers; [and]

994 (viii) Family composition, provided the small employer carrier shall
995 utilize only one or more of the following billing classifications: (I)
996 Employee; (II) employee plus family; (III) employee and spouse; (IV)
997 employee and child; (V) employee plus one dependent; and (VI)
998 employee plus two or more dependents; and

999 (ix) Status as smoker or nonsmoker.

1000 (B) The small employer carrier shall quote premium rates to small
1001 employers after receipt of all demographic rating classifications of the
1002 small employer group. No small employer carrier may inquire
1003 regarding health status or claims experience of the small employer or

1004 its employees or dependents prior to the quoting of a premium rate.

1005 (C) The provisions of subparagraphs (A) and (B) of this subdivision
1006 shall apply to plans or arrangements issued on or after July 1, 1995.
1007 The provisions of subparagraphs (A) and (B) of this subdivision shall
1008 apply to plans or arrangements issued prior to July 1, 1995, as of the
1009 date of the first rating period commencing on or after that date, but no
1010 later than July 1, 1996.

1011 (6) For any small employer plan or arrangement on which the
1012 premium rates for employee and dependent coverage or both, vary
1013 among employees, such variations shall be based solely on age and
1014 other demographic factors permitted under subparagraph (A) of
1015 subdivision (5) of this section and such variations may not be based on
1016 health status, claim experience, or duration of coverage of specific
1017 enrollees. Except as otherwise provided in subdivision (1) of this
1018 section, any adjustment in premium rates charged for a small
1019 employer plan or arrangement to reflect changes in case characteristics
1020 prior to the end of a rating period shall not include any adjustment to
1021 reflect the health status, medical history or medical underwriting
1022 classification of any new enrollee for whom coverage begins during
1023 the rating period.

1024 (7) For rating periods commencing prior to July 1, 1995, in any case
1025 where a small employer carrier utilized industry classification as a case
1026 characteristic in establishing premium rates, the rate factor associated
1027 with any industry classification shall not vary from the arithmetical
1028 average of the highest and lowest rate factors associated with all
1029 industry classifications by greater than fifteen per cent of such average.

1030 (8) Differences in base premium rates charged for health benefit
1031 plans by a small employer carrier shall be reasonable and reflect
1032 objective differences in plan design, not including differences due to
1033 the nature of the groups assumed to select particular health benefit
1034 plans.

1035 (9) For rating periods commencing prior to July 1, 1995, in any case

1036 where an insurer issues or offers a policy or contract under which
1037 premium rates for a specific small employer are established or
1038 adjusted in part based upon the actual or expected variation in claim
1039 costs or actual or expected variation in health conditions of the
1040 employees or dependents of such small employer, the insurer shall
1041 make reasonable disclosure of such rating practices in solicitation and
1042 sales materials utilized with respect to such policy or contract.

1043 (10) If a small employer carrier denies coverage to a small employer,
1044 the small employer carrier shall promptly offer the small employer the
1045 opportunity to purchase a special health care plan or a small employer
1046 health care plan, as appropriate. If a small employer carrier or any
1047 producer representing that carrier fails, for any reason, to offer such
1048 coverage as requested by a small employer, that small employer carrier
1049 shall promptly offer the small employer an opportunity to purchase a
1050 special health care plan or a small employer health care plan, as
1051 appropriate.

1052 (11) No small employer carrier or producer shall, directly or
1053 indirectly, engage in the following activities:

1054 (A) Encouraging or directing small employers to refrain from filing
1055 an application for coverage with the small employer carrier because of
1056 the health status, claims experience, industry, occupation or
1057 geographic location of the small employer, except the provisions of
1058 this subparagraph shall not apply to information provided by a small
1059 employer carrier or producer to a small employer regarding the
1060 carrier's established geographic service area or a restricted network
1061 provision of a small employer carrier; or

1062 (B) Encouraging or directing small employers to seek coverage from
1063 another carrier because of the health status, claims experience,
1064 industry, occupation or geographic location of the small employer.

1065 (12) No small employer carrier shall, directly or indirectly, enter into
1066 any contract, agreement or arrangement with a producer that provides
1067 for or results in the compensation paid to a producer for the sale of a

1068 health benefit plan to be varied because of the health status, claims
1069 experience, industry, occupation or geographic area of the small
1070 employer. A small employer carrier shall provide reasonable
1071 compensation, as provided under the plan of operation of the
1072 program, to a producer, if any, for the sale of a special or a small
1073 employer health care plan. No small employer carrier shall terminate,
1074 fail to renew or limit its contract or agreement of representation with a
1075 producer for any reason related to the health status, claims experience,
1076 occupation, or geographic location of the small employers placed by
1077 the producer with the small employer carrier.

1078 (13) No small employer carrier or producer shall induce or
1079 otherwise encourage a small employer to separate or otherwise
1080 exclude an employee from health coverage or benefits provided in
1081 connection with the employee's employment.

1082 (14) Denial by a small employer carrier of an application for
1083 coverage from a small employer shall be in writing and shall state the
1084 reasons for the denial.

1085 (15) No small employer carrier or producer shall disclose (A) to a
1086 small employer the fact that any or all of the eligible employees of such
1087 small employer have been or will be reinsured with the pool, or (B) to
1088 any eligible employee or dependent the fact that he has been or will be
1089 reinsured with the pool.

1090 (16) If a small employer carrier enters into a contract, agreement or
1091 other arrangement with another party to provide administrative,
1092 marketing or other services related to the offering of health benefit
1093 plans to small employers in this state, the other party shall be subject
1094 to the provisions of this section.

1095 (17) The commissioner may adopt regulations in accordance with
1096 the provisions of chapter 54 setting forth additional standards to
1097 provide for the fair marketing and broad availability of health benefit
1098 plans to small employers.

1099 (18) Each small employer carrier shall maintain at its principle place
1100 of business a complete and detailed description of its rating practices
1101 and renewal underwriting practices, including information and
1102 documentation that demonstrates that its rating methods and practices
1103 are based upon commonly accepted actuarial assumptions and are in
1104 accordance with sound actuarial principles. Each small employer
1105 carrier shall file with the commissioner annually, on or before March
1106 fifteenth, an actuarial certification certifying that the carrier is in
1107 compliance with this part and that the rating methods have been
1108 derived using recognized actuarial principles consistent with the
1109 provisions of sections 38a-564 to 38a-573, inclusive. Such certification
1110 shall be in a form and manner and shall contain such information, as
1111 determined by the commissioner. A copy of the certification shall be
1112 retained by the small employer carrier at its principle place of business.
1113 Any information and documentation described in this subdivision but
1114 not subject to the filing requirement shall be made available to the
1115 commissioner upon his request. Except in cases of violations of
1116 sections 38a-564 to 38a-573, inclusive, the information shall be
1117 considered proprietary and trade secret information and shall not be
1118 subject to disclosure by the commissioner to persons outside of the
1119 department except as agreed to by the small employer carrier or as
1120 ordered by a court of competent jurisdiction.

1121 (19) The commissioner may suspend all or any part of this section
1122 relating to the premium rates applicable to one or more small
1123 employers for one or more rating periods upon a filing by the small
1124 employer carrier and a finding by the commissioner that either the
1125 suspension is reasonable in light of the financial condition of the
1126 carrier or that the suspension would enhance the efficiency and
1127 fairness of the marketplace for small employer health insurance.

1128 (20) For rating periods commencing prior to July 1, 1995, a small
1129 employer carrier shall quote premium rates to any small employer
1130 within thirty days after receipt by the carrier of such employer's
1131 completed application.

1132 (21) Any violation of subdivisions (10) to (16), inclusive, and any
1133 regulations established under subdivision (17) of this section shall be
1134 an unfair and prohibited practice under sections 38a-815 to 38a-830,
1135 inclusive.

1136 (22) With respect to plans or arrangements issued pursuant to
1137 subsection (i) of section 5-259, or by an association group plan, at the
1138 option of the Comptroller or the administrator of the association group
1139 plan, the premium rates charged or offered to small employers
1140 purchasing health insurance shall not be subject to this section,
1141 provided (A) the plan or plans offered or issued cover such small
1142 employers as a single entity and cover not less than ten thousand
1143 eligible individuals on the date issued, (B) each small employer is
1144 charged or offered the same premium rate with respect to each eligible
1145 individual and dependent, and (C) the plan or plans are written on a
1146 guaranteed issue basis.

1147 Sec. 23. (NEW) (*Effective July 1, 2007*) There is established, within
1148 existing appropriations, a Quit for Good program, which shall be a
1149 smoking cessation program administered by the Department of Public
1150 Health. The department shall contract with one or more entities to
1151 implement the program, which shall (1) promote smoking cessation
1152 among unserved or underserved populations, (2) educate the public
1153 regarding the health complications relating to smoking, (3) educate the
1154 public regarding methods to quit smoking, (4) provide counseling and
1155 referral services for treatment, and (5) establish a system to track and
1156 monitor all individuals receiving smoking cessation assistance in the
1157 program. For purposes of this section, "unserved or underserved
1158 populations" means individuals who are at or below two hundred per
1159 cent of the federal poverty level and without health insurance that
1160 comprehensively covers smoking cessation.

1161 Sec. 24. Subsection (a) of section 12-202a of the general statutes is
1162 repealed and the following is substituted in lieu thereof (*Effective July*
1163 *1, 2007*):

1164 (a) Each health care center, as defined in section 38a-175, that is

1165 governed by sections 38a-175 to 38a-192, inclusive, shall pay a tax to
1166 the Commissioner of Revenue Services for the calendar year
1167 commencing on January 1, [1995] 2008, and annually thereafter, at the
1168 rate of one and [three-quarters] one-half per cent of the total net direct
1169 subscriber charges received by such health care center during each
1170 such calendar year on any new or renewal contract or policy approved
1171 by the Insurance Commissioner under section 38a-183. Such payment
1172 shall be in addition to any other payment required under section 38a-
1173 48.

1174 Sec. 25. Subdivision (37) of subsection (a) of section 12-407 of the
1175 general statutes is repealed and the following is substituted in lieu
1176 thereof (*Effective July 1, 2007, and applicable to sales occurring on and after*
1177 *July 1, 2007*):

1178 (37) "Services" for purposes of subdivision (2) of this subsection,
1179 means:

1180 (A) Computer and data processing services, including, but not
1181 limited to, time, programming, code writing, modification of existing
1182 programs, feasibility studies and installation and implementation of
1183 software programs and systems even where such services are rendered
1184 in connection with the development, creation or production of canned
1185 or custom software or the license of custom software, and exclusive of
1186 services rendered in connection with the creation, development
1187 hosting or maintenance of all or part of a web site which is part of the
1188 graphical, hypertext portion of the Internet, commonly referred to as
1189 the World Wide Web;

1190 (B) Credit information and reporting services;

1191 (C) Services by employment agencies and agencies providing
1192 personnel services;

1193 (D) Private investigation, protection, patrol work, watchman and
1194 armored car services, exclusive of (i) services of off-duty police officers
1195 and off-duty firefighters, and (ii) coin and currency services provided

1196 to a financial services company by or through another financial
1197 services company. For purposes of this subparagraph, "financial
1198 services company" has the same meaning as provided under
1199 subparagraphs (A) to (H), inclusive, of subdivision (6) of subsection (a)
1200 of section 12-218b;

1201 (E) Painting and lettering services;

1202 (F) Photographic studio services;

1203 (G) Telephone answering services;

1204 (H) Stenographic services;

1205 (I) Services to industrial, commercial or income-producing real
1206 property, including, but not limited to, such services as management,
1207 electrical, plumbing, painting and carpentry and excluding any such
1208 services rendered in the voluntary evaluation, prevention, treatment,
1209 containment or removal of hazardous waste, as defined in section
1210 22a-115, or other contaminants of air, water or soil, provided
1211 income-producing property shall not include property used
1212 exclusively for residential purposes in which the owner resides and
1213 which contains no more than three dwelling units, or a housing facility
1214 for low and moderate income families and persons owned or operated
1215 by a nonprofit housing organization, as defined in subdivision (29) of
1216 section 12-412;

1217 (J) Business analysis, management, management consulting and
1218 public relations services, excluding (i) any environmental consulting
1219 services, (ii) any training services provided by an institution of higher
1220 education licensed or accredited by the Board of Governors of Higher
1221 Education pursuant to section 10a-34, and (iii) on and after January 1,
1222 1994, any business analysis, management, management consulting and
1223 public relations services when such services are rendered in connection
1224 with an aircraft leased or owned by a certificated air carrier or in
1225 connection with an aircraft which has a maximum certificated take-off
1226 weight of six thousand pounds or more;

1227 (K) Services providing "piped-in" music to business or professional
1228 establishments;

1229 (L) Flight instruction and chartering services by a certificated air
1230 carrier on an aircraft, the use of which for such purposes, but for the
1231 provisions of subdivision (4) of section 12-410 and subdivision (12) of
1232 section 12-411, would be deemed a retail sale and a taxable storage or
1233 use, respectively, of such aircraft by such carrier;

1234 (M) Motor vehicle repair services, including any type of repair,
1235 painting or replacement related to the body or any of the operating
1236 parts of a motor vehicle;

1237 (N) Motor vehicle parking, including the provision of space, other
1238 than metered space, in a lot having thirty or more spaces, excluding (i)
1239 space in a seasonal parking lot provided by a person who is exempt
1240 from taxation under this chapter pursuant to subdivision (1), (5) or (8)
1241 of section 12-412, (ii) space in a parking lot owned or leased under the
1242 terms of a lease of not less than ten years' duration and operated by an
1243 employer for the exclusive use of its employees, (iii) valet parking
1244 provided at any airport, and (iv) space in municipally-operated
1245 railroad parking facilities in municipalities located within an area of
1246 the state designated as a severe nonattainment area for ozone under
1247 the federal Clean Air Act or space in a railroad parking facility in a
1248 municipality located within an area of the state designated as a severe
1249 nonattainment area for ozone under the federal Clean Air Act owned
1250 or operated by the state on or after April 1, 2000;

1251 (O) Radio or television repair services;

1252 (P) Furniture reupholstering and repair services;

1253 (Q) Repair services to any electrical or electronic device, including,
1254 but not limited to, equipment used for purposes of refrigeration or
1255 air-conditioning;

1256 (R) Lobbying or consulting services for purposes of representing the
1257 interests of a client in relation to the functions of any governmental

1258 entity or instrumentality;

1259 (S) Services of the agent of any person in relation to the sale of any
1260 item of tangible personal property for such person, exclusive of the
1261 services of a consignee selling works of art, as defined in subsection (b)
1262 of section 12-376c, or articles of clothing or footwear intended to be
1263 worn on or about the human body other than (i) any special clothing
1264 or footwear primarily designed for athletic activity or protective use
1265 and which is not normally worn except when used for the athletic
1266 activity or protective use for which it was designed, and (ii) jewelry,
1267 handbags, luggage, umbrellas, wallets, watches and similar items
1268 carried on or about the human body but not worn on the body in the
1269 manner characteristic of clothing intended for exemption under
1270 subdivision (47) of section 12-412, under consignment, exclusive of
1271 services provided by an auctioneer;

1272 (T) Locksmith services;

1273 (U) Advertising or public relations services, including layout, art
1274 direction, graphic design, mechanical preparation or production
1275 supervision, not related to the development of media advertising or
1276 cooperative direct mail advertising;

1277 (V) Landscaping and horticulture services;

1278 (W) Window cleaning services;

1279 (X) Maintenance services;

1280 (Y) Janitorial services;

1281 (Z) Exterminating services;

1282 (AA) Swimming pool cleaning and maintenance services;

1283 (BB) Miscellaneous personal services included in industry group 729
1284 in the Standard Industrial Classification Manual, United States Office
1285 of Management and Budget, 1987 edition, or U.S. industry 532220,
1286 812191, 812199 or 812990 in the North American Industrial

1287 Classification System United States Manual, United States Office of
1288 Management and Budget, 1997 edition, exclusive of (i) services
1289 rendered by massage therapists licensed pursuant to chapter 384a, and
1290 (ii) services rendered by an electrologist licensed pursuant to chapter
1291 388;

1292 (CC) Any repair or maintenance service to any item of tangible
1293 personal property including any contract of warranty or service related
1294 to any such item;

1295 (DD) Business analysis, management or managing consulting
1296 services rendered by a general partner, or an affiliate thereof, to a
1297 limited partnership, provided (i) the general partner, or an affiliate
1298 thereof, is compensated for the rendition of such services other than
1299 through a distributive share of partnership profits or an annual
1300 percentage of partnership capital or assets established in the limited
1301 partnership's offering statement, and (ii) the general partner, or an
1302 affiliate thereof, offers such services to others, including any other
1303 partnership. As used in this subparagraph "an affiliate of a general
1304 partner" means an entity which is directly or indirectly owned fifty per
1305 cent or more in common with a general partner;

1306 (EE) Notwithstanding the provisions of section 12-412, except
1307 subdivision (87) of said section 12-412, patient care services, as defined
1308 in subdivision (29) of this subsection by a hospital, except that "sale"
1309 and "selling" does not include such patient care services for which
1310 payment is received by the hospital during the period commencing
1311 July 1, 2001, and ending June 30, 2003;

1312 [(FF) Health and athletic club services, exclusive of (i) any such
1313 services provided without any additional charge which are included in
1314 any dues or initiation fees paid to any such club, which dues or fees
1315 are subject to tax under section 12-543, (ii) any such services provided
1316 by a municipality or an organization that is described in Section 501(c)
1317 of the Internal Revenue Code of 1986, or any subsequent
1318 corresponding internal revenue code of the United States, as from time
1319 to time amended, and (iii) yoga instruction provided at a yoga studio.]

1320 (FF) Services rendered by any person related to the sale of surgical
1321 and nonsurgical cosmetic medical procedures which are directed at
1322 improving appearance and which do not meaningfully promote the
1323 proper function of the body or prevent or treat illness or disease,
1324 including, but not limited to, cosmetic surgery, hair transplants,
1325 cosmetic injections, cosmetic soft tissue fillers, dermabrasion and
1326 chemical peel, laser hair removal, laser skin resurfacing, laser
1327 treatment of leg veins, sclerotherapy and cosmetic dentistry. "Cosmetic
1328 medical procedure" does not include reconstructive surgery or
1329 dentistry, including any surgery or dentistry performed on abnormal
1330 structures caused by or related to congenital defects, developmental
1331 abnormalities, trauma, infection, tumors or disease, or procedures to
1332 improve function or give a more normal appearance. "Cosmetic
1333 surgery" means the surgical reshaping of normal structures on the
1334 body to improve the body image, self-esteem or appearance of an
1335 individual.

1336 Sec. 26. Section 12-412 of the general statutes is amended by adding
1337 subdivision (117) as follows (*Effective July 1, 2007, and applicable to sales*
1338 *occurring on and after July 1, 2007*):

1339 (NEW) (117) Dues and fees paid to health and fitness centers if the
1340 dues and fees are paid solely for health benefit activities.

1341 Sec. 27. Section 38a-497 of the general statutes is repealed and the
1342 following is substituted in lieu thereof (*Effective July 1, 2007*):

1343 Every individual health insurance policy providing coverage of the
1344 type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of
1345 section 38a-469 delivered, issued for delivery, amended or renewed in
1346 this state on or after [October 1, 1982] July 1, 2007, shall provide that
1347 coverage of a child shall terminate no earlier than the policy
1348 anniversary date on or after whichever of the following occurs first, the
1349 date on which the child marries [, ceases to be a dependent of the
1350 policyholder, attains the age of nineteen if the child is not a full-time
1351 student at an accredited institution,] or attains the age of [twenty-three
1352 if the child is a full-time student at an accredited institution] twenty-

1353 six.

1354 Sec. 28. (NEW) (*Effective July 1, 2007*) (a) No insurer, health care
1355 center, hospital and medical service corporation or other entity
1356 delivering, issuing for delivery, renewing, continuing or amending any
1357 individual health insurance policy in this state on or after October 1,
1358 2007, shall deliver or issue for delivery in this state any policy
1359 providing limited benefit coverage unless the applicant for such
1360 coverage signs a statement on the application form that confirms that
1361 such applicant is covered under another health benefits plan contract
1362 or policy.

1363 (b) Each individual health insurance policy, subscriber contract or
1364 certificate of coverage delivered or issued for delivery in this state on
1365 or after October 1, 2007, that provides limited benefit coverage shall
1366 include the following statement printed in capital letters not less than
1367 twelve-point bold face type and located in a conspicuous manner on
1368 such policy, contract or certificate:

1369 "THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE
1370 COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR
1371 LIMITED BENEFITS POLICY AND CONTAINS SPECIFIC DOLLAR
1372 LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH
1373 MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS
1374 THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS
1375 RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS."

1376 (c) For the purposes of this section, "limited benefit coverage" means
1377 an insurance policy that is designed, advertised and marketed to
1378 supplement major medical insurance and that includes accident only,
1379 dental only, vision only, disability income only, fixed or hospital
1380 indemnity, specified disease insurance, credit insurance, Taft-Hartley
1381 trusts or that covers more than a single disease or service but has an
1382 aggregate limit less than one hundred thousand dollars or a per service
1383 or per condition limit of less than twenty thousand dollars.

1384 Sec. 29. (NEW) (*Effective July 1, 2007*) (a) No insurer, health care

1385 center, hospital and medical service corporation or other entity
1386 delivering, issuing for delivery, renewing, continuing or amending any
1387 group health insurance policy in this state on or after October 1, 2007,
1388 shall deliver or issue for delivery in this state any policy providing
1389 limited benefit coverage unless each employee electing such coverage
1390 confirms, in writing, that such employee is covered under another
1391 health benefits plan contract or policy. Each employer that offers a
1392 group health insurance policy that provides limited benefit coverage to
1393 its employees shall (1) have each employee electing such coverage sign
1394 a statement that confirms that such employee is covered under another
1395 health benefits plan contract or policy, and (2) submit such statement
1396 to such insurer, health care center, hospital and medical service
1397 corporation or other entity.

1398 (b) Each group health insurance policy, subscriber contract or
1399 certificate of coverage delivered or issued for delivery in this state on
1400 or after October 1, 2007, that provides limited benefit coverage shall
1401 include the following statement printed in capital letters not less than
1402 twelve-point bold face type and located in a conspicuous manner on
1403 such policy, contract or certificate:

1404 "THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE
1405 COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR
1406 LIMITED BENEFITS POLICY AND CONTAINS SPECIFIC DOLLAR
1407 LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH
1408 MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS
1409 THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS
1410 RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS."

1411 (c) For the purposes of this section, "limited benefit coverage" means
1412 an insurance policy that is designed, advertised and marketed to
1413 supplement major medical insurance and that includes accident only,
1414 dental only, vision only, disability income only, fixed or hospital
1415 indemnity, specified disease insurance, credit insurance, Taft-Hartley
1416 trusts or that covers more than a single disease or service but has an
1417 aggregate limit less than one hundred thousand dollars or a per service

1418 or per condition limit of less than twenty thousand dollars.

1419 Sec. 30. (NEW) (*Effective July 1, 2007*) (a) There is established a
1420 permanent Commission on Healthy Lifestyles, which shall be an
1421 independent body within the Office of Health Care Access for
1422 administrative purposes only. Said commission shall: (1) By October 1,
1423 2007, develop a marketing campaign to educate the public regarding
1424 consequences of poor health and basic measures individuals should
1425 take to ensure good health; and (2) make recommendations to the
1426 General Assembly concerning incentives to encourage personal
1427 responsibility in making healthy lifestyle choices.

1428 (b) The commission shall consist of the Commissioners of Public
1429 Health, Education, Social Services and Health Care Access, the
1430 Insurance Commissioner, or their designees, and nine additional
1431 members as follows: One member to be appointed by the Governor,
1432 two to be appointed by the president pro tempore of the Senate, two to
1433 be appointed by the speaker of the House of Representatives, one to be
1434 appointed by the majority leader of the Senate, one to be appointed by
1435 the majority leader of the House of Representatives, one to be
1436 appointed by the minority leader of the Senate, and one to be
1437 appointed by the minority leader of the House of Representatives.

1438 (c) Notwithstanding the provisions of subsection (c) of section 4-9a
1439 of the general statutes, the members of the commission shall serve for
1440 staggered terms. The initial members selected shall serve as follows: (1)
1441 The members appointed by the Governor and the president pro
1442 tempore of the Senate shall serve for three years; (2) the members
1443 appointed by the speaker of the House of Representatives and the
1444 majority leader of the Senate shall serve for two years; and (3) the
1445 members appointed by the majority leader and the minority leader of
1446 the House of Representatives and the minority leader of the Senate
1447 shall serve for one year. Following the expiration of such initial terms,
1448 each subsequent appointee shall serve for a term of three years. Any
1449 vacancy shall be filled by the appointing authority for the unexpired
1450 portion of the term of the member replaced. The members shall serve

1451 without compensation for their services but shall be reimbursed for
1452 their duties.

1453 (d) The commission shall meet at least quarterly each year. The
1454 commission, within available appropriations, may hire consultants to
1455 provide assistance with its responsibilities.

1456 (e) The Office of Health Care Access shall, within available
1457 appropriations, contract with one or more entities to implement the
1458 marketing campaign recommended by the Commission on Healthy
1459 Lifestyles.

1460 Sec. 31. (NEW) (*Effective July 1, 2007*) Not later than July 1, 2009, the
1461 Health Care Reform Commission, established under section 2 of this
1462 act, shall establish a nonprofit organization to be known as the
1463 Connecticut Health Quality Partnership. The Connecticut Health
1464 Quality Partnership shall: (1) Be responsible for collecting and
1465 reporting insurance claims data and other data concerning the quality
1466 of care and services provided by health plans, hospitals and health
1467 care providers for the purpose of supporting quality improvement
1468 initiatives and enabling consumers to make informed choices with
1469 respect to such providers, (2) be composed of representatives from
1470 both the private and public sectors, including, but not limited to,
1471 health insurers, hospital associations, medical societies, the
1472 Commissioners of Public Health and Social Services and consumer
1473 advocates who are not otherwise affiliated with any other members,
1474 and (3) seek funding from private and federal funding sources.

1475 Sec. 32. (NEW) (*Effective July 1, 2007*) No physician licensed under
1476 chapter 370 of the general statutes and no hospital licensed under
1477 chapter 368v of the general statutes which does not have a contract
1478 with a third-party payer or which provides medical services or
1479 treatment to persons who do not have health insurance coverage shall
1480 charge fees for such services or treatment that exceed two hundred per
1481 cent of those fees allowed by the federal Medicare program for such
1482 services or treatment.

1483 Sec. 33. Subsection (d) of section 17b-192 of the general statutes is
1484 repealed and the following is substituted in lieu thereof (*Effective July*
1485 *1, 2007*):

1486 (d) The Commissioner of Social Services shall contract with
1487 federally qualified health centers or other primary care providers as
1488 necessary to provide medical services to eligible state-administered
1489 general assistance recipients pursuant to this section. The
1490 commissioner shall [, within available appropriations,] make payments
1491 to such centers based on their pro rata share of the cost of services
1492 provided or the number of clients served, or both. The Commissioner
1493 of Social Services shall [, within available appropriations,] make
1494 payments to other providers based on a methodology determined by
1495 the commissioner. The Commissioner of Social Services may reimburse
1496 for extraordinary medical services, provided such services are
1497 documented to the satisfaction of the commissioner. For purposes of
1498 this section, the commissioner may contract with a managed care
1499 organization or other entity to perform administrative functions,
1500 including a grievance process for recipients to access review of a denial
1501 of coverage for a specific medical service, and to operate the program
1502 in whole or in part. Provisions of a contract for medical services
1503 entered into by the commissioner pursuant to this section shall
1504 supersede any inconsistent provision in the regulations of Connecticut
1505 state agencies. A recipient who has exhausted the grievance process
1506 established through such contract and wishes to seek further review of
1507 the denial of coverage for a specific medical service may request a
1508 hearing in accordance with the provisions of section 17b-60. On July 1,
1509 2007, the amount paid pursuant to this section to each federally
1510 qualified health center or other primary care provider shall be
1511 increased by not less than five per cent. On July 1, 2008, and annually
1512 thereafter, such payments shall increase by not less than the
1513 percentage increase in the consumer price index.

1514 Sec. 34. Section 12-296 of the general statutes is repealed and the
1515 following is substituted in lieu thereof (*Effective July 1, 2007, and*
1516 *applicable to sales occurring on or after July 1, 2007*):

1517 A tax is imposed on all cigarettes held in this state by any person for
1518 sale, said tax to be at the rate of [seventy-five] eighty-two and one-half
1519 mills for each cigarette and the payment thereof shall be for the
1520 account of the purchaser or consumer of such cigarettes and shall be
1521 evidenced by the affixing of stamps to the packages containing the
1522 cigarettes as provided in this chapter.

1523 Sec. 35. (NEW) (*Effective July 1, 2007*) (a) On October 1, 2007, and
1524 every five years thereafter, the Office of Health Care Access shall
1525 determine the number of Connecticut residents who are not covered
1526 by a health insurance plan. If the number of uninsured residents has
1527 not decreased by fifty per cent by October 1, 2012, the Health Care
1528 Reform Commission shall determine whether it is advisable to require
1529 residents to have health insurance. Not later than January 1, 2013, the
1530 commission shall report its findings to the joint standing committee of
1531 the General Assembly having cognizance of matters relating to
1532 insurance.

1533 (b) Not later than December 31, 2007, and annually thereafter, the
1534 Office of Health Care Access shall conduct a survey to determine the
1535 number of Connecticut employers that are providing health care
1536 benefits to employees who reside in this state. Not later than January 1,
1537 2008, and annually thereafter, said office shall submit a report of its
1538 findings to the joint standing committee of the General Assembly
1539 having cognizance of matters relating to insurance.

1540 Sec. 36. (*Effective July 1, 2007*) Notwithstanding the provisions of
1541 section 4-28e of the general statutes, the sum remaining in the Tobacco
1542 and Health Trust Fund shall be transferred from said fund to the
1543 General Fund, of which twenty million dollars shall be used by the
1544 Department of Public Health for the Smoke-Free Connecticut Program.

1545 Sec. 37. (*Effective July 1, 2007*) The sum of one million six hundred
1546 thousand dollars is appropriated to the Department of Public Health,
1547 from the General Fund, for the fiscal year ending June 30, 2008, for the
1548 purpose of providing grants in the amount of two hundred thousand
1549 dollars to eight different groups representing the interests of

1550 Connecticut employers. Such grants shall be used to train employers to
 1551 effectively educate employees concerning the financial and health
 1552 benefits of making lifestyle choices that promote good health,
 1553 including maintaining a healthy weight and regularly exercising.

1554 Sec. 38. (*Effective July 1, 2007*) An amount is appropriated to the
 1555 Department of Social Services, from the General Fund, for the fiscal
 1556 year ending June 30, 2008, for the purposes of section 17 of this act.

1557 Sec. 39. (*Effective July 1, 2007*) The sum of five hundred thousand
 1558 dollars is appropriated to the Department of Social Services, from the
 1559 General Fund, for the fiscal year ending June 30, 2008, for the purpose
 1560 of providing grants to community-based organizations under
 1561 subsection (e) of section 17b-297 of the general statutes, as amended by
 1562 this act.

1563 Sec. 40. (*Effective July 1, 2007*) The sum of one million dollars is
 1564 appropriated to the Insurance Department, from the General Fund, for
 1565 the fiscal year ending June 30, 2008, for the purpose of providing start-
 1566 up costs for the Connecticut Connector.

1567 Sec. 41. Section 17b-261c of the general statutes is repealed. (*Effective*
 1568 *July 1, 2007*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2007</i>	New section
Sec. 2	<i>July 1, 2007</i>	New section
Sec. 3	<i>July 1, 2007</i>	New section
Sec. 4	<i>July 1, 2007</i>	New section
Sec. 5	<i>July 1, 2007</i>	New section
Sec. 6	<i>July 1, 2007</i>	New section
Sec. 7	<i>July 1, 2007</i>	New section
Sec. 8	<i>July 1, 2007</i>	New section
Sec. 9	<i>July 1, 2007</i>	New section
Sec. 10	<i>July 1, 2007</i>	New section
Sec. 11	<i>July 1, 2007</i>	New section
Sec. 12	<i>July 1, 2007</i>	New section

Sec. 13	<i>July 1, 2007</i>	New section
Sec. 14	<i>July 1, 2007</i>	New section
Sec. 15	<i>July 1, 2007</i>	New section
Sec. 16	<i>July 1, 2007</i>	17b-267
Sec. 17	<i>July 1, 2007</i>	New section
Sec. 18	<i>July 1, 2007</i>	17b-297
Sec. 19	<i>July 1, 2007</i>	17b-261(a)
Sec. 20	<i>July 1, 2007</i>	17b-261
Sec. 21	<i>July 1, 2007</i>	17b-292
Sec. 22	<i>July 1, 2007</i>	38a-567
Sec. 23	<i>July 1, 2007</i>	New section
Sec. 24	<i>July 1, 2007</i>	12-202a(a)
Sec. 25	<i>July 1, 2007, and applicable to sales occurring on and after July 1, 2007</i>	12-407(a)(37)
Sec. 26	<i>July 1, 2007, and applicable to sales occurring on and after July 1, 2007</i>	12-412
Sec. 27	<i>July 1, 2007</i>	38a-497
Sec. 28	<i>July 1, 2007</i>	New section
Sec. 29	<i>July 1, 2007</i>	New section
Sec. 30	<i>July 1, 2007</i>	New section
Sec. 31	<i>July 1, 2007</i>	New section
Sec. 32	<i>July 1, 2007</i>	New section
Sec. 33	<i>July 1, 2007</i>	17b-192(d)
Sec. 34	<i>July 1, 2007, and applicable to sales occurring on or after July 1, 2007</i>	12-296
Sec. 35	<i>July 1, 2007</i>	New section
Sec. 36	<i>July 1, 2007</i>	New section
Sec. 37	<i>July 1, 2007</i>	New section
Sec. 38	<i>July 1, 2007</i>	New section
Sec. 39	<i>July 1, 2007</i>	New section
Sec. 40	<i>July 1, 2007</i>	New section
Sec. 41	<i>July 1, 2007</i>	Repealer section

APP *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 chamber thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 08 \$	FY 09 \$
Department of Social Services	GF - Cost	Significant	Significant
Insurance Department	GF - Cost	1,000,000	See Below
Department of Revenue Services	GF - Cost	Significant	Significant
Department of Revenue Services	GF - Revenue Impact	See Below	See Below
Office of Health Care Access	Various - Cost	See Below	See Below

Municipal Impact: None

Explanation

This bill makes various changes to the health care system in Connecticut, as detailed below.

Sections 1 and 2 establish a twelve member Health Care Reform Commission, and place it within the Office of Health Care Access (OHCA) for administrative purposes only. As members are entitled to reimbursement for expenses, associated minimal costs will be incurred by the Office.

Costs of consultant services needed to assist the Commission cannot be determined in advance. However, they would be anticipated to be significant in magnitude. For comparison purposes, the Governor has recommended \$500,000 in FY 08 under OHCA's budget to support research and planning efforts to be undertaken by a proposed Electronic Health Information Technology Task Force. It is assumed that a comparable expense would be incurred by the Commission to comply with subdivision 5 of Section 2(c). Additional indeterminate costs would be associated with accomplishing other mandates within this subsection.

Should no appropriation be included within the enacted FY 08-09 Biennial Budget for consultant services, the requirement that associated costs be accommodated within available appropriations will likely result in one of four outcomes: (1) The Commission will proceed, and OHCA will require a deficiency appropriation; (2) the Commission will delay implementation pending the approval of additional appropriations in future fiscal years to OHCA; (3) OHCA will shift resources from other departmental priorities, thereby impacting existing departmental programs; or (4) the Commission will be unable to proceed.

It should be noted that administrative services are currently provided to OHCA by the Department of Administrative Services (DAS). Therefore, a workload increase will be experienced by DAS to the extent that additional services are required.

It is anticipated that the Commissioners of Social Services, Health Care Access, and Insurance, or their designees, will participate in the activities of the Commission within each agency's normally budgeted resources.

Sections 3 of the bill requires the Insurance Department to develop, issue a request for proposals (RFP) and award a five-year contract to administer the Connecticut Connector. Section 40 of the bill appropriates \$1,000,000 to the department for the process.

The Connector will serve as a health insurance purchasing pool, through which previously uninsured individuals and employers who previously did not offer health insurance may purchase health plans. The administrator of the Connector must solicit insurers to sell product through the Connector, review and publicize plan benefits and costs, screen applicants, among other duties. The administrator must collect premium contributions from employers and individuals, as well as any subsidies from the state. The bill allows the administrator to collect fees from each insurer selling products through the Connector in order to support administrative costs. It thus appears that beyond the \$1,000,000 provided to develop and issue the RFP, the state does not

incur any direct costs from the operation of the Connector.

Sections 4 and 5 of the bill specify what types of health plans will be provided under the Connector as well as what individuals and employers will be eligible to purchase insurance through the Connector. There is no fiscal impact to the state from these provisions.

Sections 6 through 9 of the bill establish a refundable tax credits for small business offering employees health insurance. The credit may be applied against the: (1) corporation business tax, (2) business entity tax, or (3) the personal income tax. This is anticipated to result in a significant General Fund annual revenue loss that is likely to be at least \$600,000,000¹ per year.

The bill is expected to result in a cost to the Department of Revenue Services of \$665,000 in FY 08 and \$220,000 in FY 09 to administer and audit the credit program.

It is likely that the tax credit established in this section will incent greater availability of private health insurance. Should the greater availability of private insurance lower the demand on state funded health care such as Medicaid or the State Administered General Assistance program (SAGA), the state may incur savings. The extent of these potential savings cannot be determined.

Section 10 of the bill establishes a health savings account program for families with incomes under 400% of the Federal Poverty Level (FPL) and who are enrolled in a high deductible insurance plan. The Connector must make payments to these accounts annually on a sliding fee scale specified in the bill. These payments range from \$300 to \$1,500. It is not known how many eligible health savings accounts

¹ This figure assumes employers with less than 50 employees cover approximately 276,000 employees through employee sponsored insurance (ESI) and majority of plans will at a minimum qualify for the lowest per employee credit (\$800/employee and \$2,400/employee and family). Information on the number of firms with less than 50 employees offering (ESI) was obtained from a 2004 report published by OCHA that surveyed Connecticut small employers and households. Data from the

may be established. However, given the subsidy levels specified in the bill, the Connector will incur a significant annual cost. The bill specifies that the administrator of the Connector will receive funds from the Comptroller to make these payments. Therefore, the General Fund would bear these costs.

Section 11 establishes a premium subsidy program for families with incomes under 400% FPL and who currently have private insurance. The Connector must eligible families quarterly on a sliding fee scale specified in the bill. These payments range from \$300 to \$1,500 annually depending in income and family size.

The Office of Fiscal Analysis (OFA) estimates that there are approximately 950,000 individuals (365,000 households) under 400% FPL who are covered by private insurance. The family size and income distribution is not known. It is also not known how many of these households have private insurance that meets the terms specified in the bill. However, assuming that half of the households are enrolled in the required insurance, and receive an average premium subsidy (\$900), the Connector would incur an annual cost of approximately \$164,300,000. The bill specifies that the administrator of the Connector will receive funds from the Comptroller to make these payments. Therefore, the General Fund would bear these costs.

Section 12 requires the Department of Social Services (DSS) to seek a federal waiver to receive reimbursement for costs incurred under sections 10 and 11 and to establish a Medicaid funded excess cost reinsurance program. Should the waiver be granted, the state would receive 50% reimbursement for the costs incurred by the Connector under sections 10 and 11. The state cost for the excess cost reinsurance program will be dependent upon the structure of the waiver submitted to the federal government, which is not now known.

Section 13 specifies that no employer may offer health benefits of a

Department of Labor was also used to estimate the number of employees employed by firms with less than 50 employees.

lesser value to lower-paid employees than higher-paid employee.

Section 14 requires DSS to develop a plan to implement a system of primary care case management (PCCM) for some or all of the aged blind or disabled Medicaid beneficiaries. These individuals currently receive unmanaged, fee-for-service benefits, with an estimated FY08 cost of \$1,300,000,000 (for approximately 74,000 clients). A PCCM system may be able to provide more coordinated care as well as reduce the annual \$17,500 cost per client. The potential savings will be dependent upon the system developed. For purposes of illustration, each 5% savings achieved would result in annual savings of approximately \$65,000,000.

Section 15 requires DSS to allow Medicaid fee-for-service beneficiaries to enroll in the managed care plans available under the HUSKY plans. The impact of this provision is uncertain. Integrating these higher cost individuals (\$17,500 per client annually as compared to \$2,600 annually for HUSKY A enrollees) will likely drive up the capitated rate paid by DSS to the managed care organizations (MCO's). However, as noted in the previous section, more coordinated care may reduce the annual medical costs for these clients.

Section 16 limits the administrative costs of HUSKY MCO's to 10%. DSS may exclude from this cap disease management or value added clinical programs, but specifically may not exclude utilization management, claims, member services or other non-clinical functions. The impact of this change is uncertain. Although the cap may reduce what the state reimburses the MCO's for administrative costs, limiting the MCO's ability to conduct utilization review may increase the medical service costs. The administrative cap may also reduce the MCO's ability to meet state and federally required reporting mandates.

Section 17 requires DSS to increase certain hospital, dental and physician rates under the Medicaid fee for service program. OFA estimates that these changes will cost \$127,100,000 in FY08 and \$133,500,000 in FY09. This section also requires that DSS amend the contracts with the HUSKY MCO's in order to implement similar rate

increases under the HUSKY program. OFA estimates that this will cost \$126,400,000 in FY08 and \$132,800,000 in FY09. The increased costs in this section would be eligible for reimbursement under the federal Medicaid and SCHIP programs.

Section 18 requires DSS to award 50 grants of up to \$10,000 to community based organizations for public education, outreach and recruitment of HUSKY eligible children. Section 40 appropriates \$500,000 in FY08 for this purpose.

Section 19 expands eligibility for parents of children enrolled in the HUSKY A program from 150% of the federal poverty level (FPL) to 185% FPL. OFA estimates that this will add an additional 9,700 clients to the program when fully annualized, at a cost of \$21,200,000 in FY08 and \$28,200,000 in FY09. This estimate includes the rate increases implemented in section 17 of the bill. These costs would be reimbursed 50% by the federal government under the Medicaid program.

Section 20 requires DSS to increase the Medicaid medically needy income limit to 150% FPL. This change is expected increase Medicaid eligibility by 31,080 individuals, at a cost of \$111,900,000 in FY08 and \$117,500,000 in FY09. These costs would be reimbursed 50% by the federal government under the Medicaid program.

Section 21 re-establishes the continuous eligibility policy for children in the HUSKY plan. Assuming the rate increases included in section 17, this change is estimated to cost \$2,500,000 annually. These costs would be reimbursed 50% by the federal government under the Medicaid program.

Section 21 also requires expedited HUSKY B enrollment of uninsured newborns and requires DSS to pay any premium costs for the first two months of coverage. There are approximately 90 uninsured births monthly in Connecticut. Enrolling these children in HUSKY B and paying full premiums for the first two months is expected to cost \$2,400,000 in FY08 and \$5,100,000 in FY09 (assuming

the rate increases in section 17 of the bill). These costs would be 65% reimbursable under the federal SCHIP program.

Section 22 makes changes to the small employer group community rating system. These changes are not anticipated to have a direct fiscal impact on the state.

Section 23 requires the Department of Public Health to establish a Quit for Good program. It is assumed for purposes of this fiscal note that the Quit for Good program is the same as the Smoke Free Connecticut Program referenced in Section 37. If these programs are not one and the same, significant costs would be added to those discussed below.

Of the \$20,000,000 transferred to the DPH by Section 37, approximately \$164,000 would be needed in FY 08 (\$160,500 commencing in FY 09, after adjusting for one-time costs) to support the salaries of 2.5 positions and related ancillary costs needed to implement this program.

Additional fringe benefits costs of \$51,230 in FY 08 and \$89,650 in FY 09 would also be incurred.²

To the extent that effective smoking cessation programming reduces the incidence of tobacco related adverse medical consequences, future reductions in expenditures under public health care programs may ensue.

Section 24 of the bill reduces the insurance premiums tax from 1.75% to 1.50% for policies written by health maintenance

² 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 for a new employee as a percentage of average salary is 25.8%, effective July 1, 2006. 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 2006-07 fringe benefit rate is 34.4%, which when combined with the non pension fringe benefit rate totals 60.2%.

organizations (HMOs) as of 7/1/07. This change is anticipated to result in a General fund revenue loss of \$500,000 per year beginning in FY 08.

Sections 25 and 26 of the bill repeal the sales tax on health club services and exempts dues paid to health and fitness center as of 7/1/07. These changes are anticipated to result in a General Fund revenue loss of \$6,100,000 per year beginning in FY 08.

Section 25 of the bill imposes the sales tax on certain cosmetic medial procedures as of 7/1/07. This change is anticipated to result in a General Fund revenue gain of \$3,200,000³ per year beginning in FY 08.

Section 27, by requiring insurance policies that cover dependent children to provide coverage until the age of 26 (regardless of educational status), will result in increased health service costs to the state as an employer beginning in FY 09. Under the bill, certain employees will maintain the more costly family coverage for longer than currently permitted. Data related to coverage of adult children to age 26 is not readily available from the Office of the State Comptroller (OSC), so a cost estimate cannot be determined at this time. To the extent that the dependent coverage required under the bill is not currently provided under a municipality's employee health insurance policy, there would be increased costs to provide it that cannot be determined.

Sections 28 and 29 concern requirements of insurers who offer limited benefit coverage. These changes are not anticipated to have a direct fiscal impact on the state.

Section 30 establishes a fourteen member Commission on Healthy Lifestyles, and places it within OHCA for administrative purposes only. As members are eligible for expense reimbursements, associated

³ This estimate is based on New Jersey's experience adjusted for Connecticut's population and rate differences. New Jersey's collects about \$8 million per year from their cosmetic tax.

minimal costs will be incurred by the Office. Should the Commission decide to retain consultant services to assist it in the development of a marketing campaign and formulation of recommended incentives encouraging personal responsibility, additional indeterminate costs will be incurred.

A cost, which may be significant in magnitude, will be incurred by OHCA to contract for the marketing campaign recommended by the Commission. Actual costs would depend upon the scope of the campaign, which cannot be determined in advance. For comparison purposes, a 2003 counter marketing campaign was implemented at a cost of \$350,000, pursuant to a recommendation of the Tobacco and Health Trust Fund Board of Trustees.⁴

It should be noted that administrative services are currently provided to OHCA by the Department of Administrative Services (DAS). Therefore, a workload increase will be experienced by DAS to the extent that additional services are required.

Should no appropriation be included within the enacted FY 08-09 Biennial Budget for the marketing campaign, the requirement that associated costs be accommodated within available appropriations will likely result in one of four outcomes detailed in section 2 above.

It is anticipated that the Commissioners of Public Health, Education, Social Services, Health Care Access, and Insurance, or their designees, will participate in the activities of the Commission within each agency's normally budgeted resources.

Section 31 requires the Health Care Reform Commission to establish a nonprofit organization, the Connecticut Health Quality Partnership (CHQP), by 7/1/09.

While the CHQP would be required to seek funding from private

⁴ The counter marketing campaign utilized 409 television spots, 1,546 radio spots, thirteen bus panels, two highway billboards, a full-page magazine print ad, and promotions involving sports events at the Hartford Civic Center.

and federal sources, presumably to support its mandated activities, no funding sources are identified at this time. It is unclear whether the absence of such financial support would result in an obligation on the state to pay costs associated with the creation or operation of the organization. Associated potential costs, which would be anticipated to be significant in magnitude, cannot be quantified at this time.

It is anticipated that the Commissioners of Public Health and Social Services, or their designees, will participate in the activities of the Commission within each agency's normally budgeted resources.

Section 32 prohibits physicians and hospitals from charging uninsured individuals fees in excess of 200% of fees allowed under Medicare. These changes are not anticipated to have a direct fiscal impact on the state.

Section 33 requires DSS to increase the rates paid to federally required health center under the State Administered General Assistance (SAGA) program by 5% in FY08 and by the consumer price index increase in subsequent years. OFA estimates that this change will cost \$4,800,000 in FY08 and \$7,300,000 in FY09. This section further eliminates the provision that DSS make payments to SAGA providers within available appropriations. OFA estimates that this would increase SAGA payments by approximately \$16,000,000 annually.

Section 34 increases the cigarette tax from \$1.51 to \$1.65 per pack as of 7/1/07. This change is anticipated to result in a General Fund revenue gain of approximately \$22,000,000 per year beginning in FY 08.

Section 35 requires the Office of Health Care Access to determine the number of uninsured Connecticut residents, by 10/1/07 and every five years thereafter. It also requires the Office to conduct a survey to determine the number of Connecticut employers providing health care benefits, by 12/31/07 and annually thereafter.

A cost, which may be significant in magnitude, will be incurred by the Office to comply with these requirements. Actual costs would depend upon the scope of the surveys conducted in any given year, but would be expected to exceed \$150,000 in years when both household and employer data is collected. (For comparison purposes, in 2006 the Office paid \$175,600 for consultant services to conduct surveys of 4,200 households and 800 employers.)

Should no appropriation be included within the enacted FY 08-09 Biennial Budget for the purposes of Section 36 the requirement that associated costs be accommodated within available appropriations will likely result in one of four outcomes detailed in section 2 above.

Section 36 transfers the sum remaining in the Tobacco and Health Trust Fund on 7/1/07 to the General Fund, of which \$20,000,000 must be used by the Department of Public Health for a Smoke Free Connecticut Program. This will reduce the principal in the THTF by an estimated \$20,800,000, and correspondingly increase the resources of the General Fund.

Section 37 appropriates \$1,600,000 to the DPH in FY 08 to allow the agency to provide eight \$200,000 grants to train employers to educate employees about the financial and health benefits of making lifestyle choices that promote good health.

Approximately \$158,200 would be needed in FY 08 (\$154,300 commencing in FY 09, after adjusting for one-time costs) to support the salaries of 2.5 positions and related ancillary costs needed to implement this program.

Additional fringe benefits costs of \$51,540 in FY 08 and \$90,190 in FY 09 would also be incurred.

To the extent that promotion of healthy lifestyle choices reduces the incidence of obesity and related adverse medical consequences, future reductions in expenditures under public health care programs may ensue.

Section 38 makes an unspecified appropriation to DSS. As no funds are actually appropriated, these sections have no fiscal impact.

Sections 39 and 40 make appropriations as noted in the above narrative.

Section 41 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 \$2,000,000 annually.

The Out Years

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

OLR Bill Analysis**sHB 6652*****AN ACT ESTABLISHING THE CONNECTICUT HEALTHY STEPS PROGRAM.*****SUMMARY:**

This bill establishes the Connecticut Healthy Steps Program, which consists of numerous health insurance requirements, tax provisions, HUSKY program changes, and public health initiatives. It establishes a Health Care Reform Commission, the Connecticut Connector, a Commission on Healthy Lifestyles, a health savings account incentive program, and a premium subsidy program. It also makes several appropriations.

EFFECTIVE DATE: July 1, 2007, except that the sales tax provisions apply to sales occurring on and after July 1, 2007.

HEALTH CARE REFORM COMMISSION (§ 2)

The bill establishes a permanent 12-member Health Care Reform Commission as an independent body in the Office of Health Care Access (OHCA) for administrative purposes only. By July 1, 2008, it must develop (1) an affordable health care plan available for sale to small employers (50 or fewer employees) through the Connecticut Connector, which the bill establishes, and (2) a comprehensive health care plan that meets current statutory requirements.

By January 1, 2009, the commission must report to the Insurance and Real Estate Committee identifying the effect of statutorily required health insurance benefits on health care premiums that private sector employers pay. Beginning January 1, 2009, it must annually make recommendations to the General Assembly about the Connecticut Healthy Steps Program and improvements to the health care system, including cost controls.

The bill requires the commission to:

1. develop incentives to encourage people to use health insurance responsibly;
2. develop a proposed plan and timetable for implementing statewide electronic prescribing, computerized physician order entry in hospitals, and a uniform electronic medical record system to improve the state's health care quality;
3. develop a plan for implementing a third-party administered pharmaceutical purchasing pool to cover all public employees and public programs;
4. establish the Connecticut Health Quality Partnership by July 1, 2009; and
5. determine whether residents should be required to have health insurance if the number of uninsured people has not decreased 50% by October 1, 2012.

Commission members include the Department of Social Services (DSS), OHCA, and insurance commissioners, or their designees, and nine appointed members. The Senate president pro tempore and House speaker each appoint two and the governor, House and Senate majority leaders, and House and Senate minority leaders each appoint one.

The initial members serve staggered terms with (1) the governor's and Senate president pro tempore's appointees serving for three years, (2) the House speaker's and Senate majority leader's appointees for two years, and (3) the remaining members for one year. After the initial terms expire, subsequent appointees serve three-year terms. The appointing authority must fill any vacancy for the unexpired term. Members are not compensated but are reimbursed for their expenses.

The bill requires the commission to meet as often as necessary to complete its work, but at least quarterly, and it can hire consultants

within available appropriations.

Connecticut Health Quality Partnership (§ 31)

The bill requires the Health Care Reform Commission to establish a nonprofit organization called the “Connecticut Health Quality Partnership” by July 1, 2009. The partnership must collect and report insurance claims and other data on the quality of care and services provided by health plans, hospitals, and health care providers to support quality improvement initiatives and help consumers make informed provider choices. It must include representatives from the public and private sectors including health insurers, hospital associations, medical societies, consumer advocates not affiliated with any other members, and the Department of Public Health (DPH) and DSS commissioners. The partnership must seek private and public funding.

CONNECTICUT CONNECTOR (§§ 3-5 & 40)

The bill requires the Insurance Department, in consultation with the Health Care Reform Commission, to develop, issue a request for proposals, and award a five-year contract to administer the Connecticut Connector (“Connector”). The contract must be awarded to a private nonprofit organization to serve as a health insurance purchasing pool, through which previously uninsured individuals and uninsured employers may purchase health plans. (Presumably “uninsured employers” means employers who do not offer employees health insurance.)

Administrator (§ 3)

The bill requires the Connector’s administrator to meet with the Health Care Reform Commission as the commission determines appropriate. The administrator must:

1. solicit insurers to sell products through the Connector;
2. review the products for compliance with Health Care Reform Commission-established benefits and standards;

3. provide plan selection assistance to, and publish easy-to-understand materials that, compare plan costs and benefits for prospective purchasers;
4. screen applicants for eligibility to purchase through the pool;
5. work with the insurers selling products through the Connector to develop a uniform tool for collecting applicant or enrollee data needed for underwriting, enrollment, and other purposes;
6. collect premium contributions from employers and individuals and subsidies from the state and remit the funds to the enrollees' health plans;
7. collect fees from each insurer selling products through the Connector, based on rules the Health Care Reform Commission adopts, to support administration costs;
8. notify insureds when premiums are late and disenroll them or charge late penalties as appropriate;
9. provide creditable coverage notices as required under the federal Health Insurance Portability and Accountability Act (HIPAA);
10. market the health plans available through the Connector to potential purchasers;
11. administer the small employer tax credit programs the bill establishes;
12. receive money from the comptroller and make payments to individuals and employers eligible under the health savings account incentive and premium assistance programs the bill establishes; and
13. beginning July 1, 2009, provide data and reports annually to the Health Care Reform Commission and the General Assembly that include (a) the number and demographics of previously uninsured people covered through the Connector, by type of

policy, (b) the Connector's per capita administrative costs, (c) any recommendations for improving service, health insurance policy offerings, and costs, and (d) any other information the commission requires.

Health Care Plans (§ 4)

The bill requires the Connector's administrator to offer the following three health insurance plans to each applicant: (1) an affordable health care plan; (2) a comprehensive health care plan currently available from insurers; and (3) a health savings account plus high deductible plan currently available from insurers. An employer purchasing coverage through the Connector may offer its employees any, but not necessarily a choice, of these plans.

The affordable health care plan must include:

1. coverage of physicians, clinics, ambulatory surgery, laboratory and diagnostic services, in-patient and out-patient hospital care, and medically necessary prescription drugs for physical or mental health;
2. coinsurance that reflects family income;
3. a copayment of up to \$75 for inappropriate use of a hospital emergency department;
4. a minimum loss ratio (the percent of each premium dollar collected that must be used to pay claims) of 85% over any three-year moving average period; and
5. a lifetime benefits maximum of \$500,000, contingent on the availability of an excess cost reinsurance program through DSS for which an individual or family would become eligible without spending all of their resources after exhausting their lifetime benefit. (It is unclear if this means that a lifetime benefit maximum is not permitted if DSS does not establish a reinsurance program.)

All Connector health care plans offered must be community-rated. The community rate is to be adjusted based on the individual's age, sex, county, and tobacco use. Each plan must also have a medical loss ratio of at least 85%.

The bill specifies that Connector health plan coverage is creditable coverage, as defined in HIPAA. (Creditable coverage is the time a person was covered under a prior plan that counts toward any preexisting condition coverage exclusion in a policy currently covering the person.) Any health plan that next covers a person who was insured through the Connector is prohibited from excluding coverage for that person's preexisting conditions. But each Connector health care plan offered may exclude coverage for preexisting conditions of anyone who has been uninsured for more than 12 months (presumably the 12 months immediately preceding the effective date of the Connector plan).

Individual Eligibility (§ 5)

The bill establishes the eligibility criteria for a person applying for individual coverage through the Connector. An eligible person (1) does not have access to employer-sponsored coverage where the employer pays at least 50% of the employee's and dependents' coverage costs; (2) has been uninsured for at least six months; or (3) has been uninsured for less than six months and lost coverage due to a major life event. Major life events include:

1. loss of coverage due to job loss;
2. death of, or abandonment by, a family member who had provided coverage;
3. loss of dependent coverage because a spouse turned age 65 and became eligible for Medicare (but loss of dependent coverage because a spouse became Medicare-eligible before age 65 because of disability is apparently not included);
4. losing coverage as a dependent under a group comprehensive

health care plan;

5. exhausting coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA);
6. extreme economic hardship on the part of either the employee or the employer, as determined by the Connector's administrator; and
7. any other events the Health Care Reform Commission may specify.

Employer Eligibility (§ 5)

The bill establishes the eligibility criteria for an employer applying for group coverage through the Connector. An eligible employer is one that (1) has 50 or fewer employees, (2) has not offered a comprehensive health insurance plan to any employee for at least six months, and (3) will contribute at least 70% of the employee coverage cost and 50% of the dependent coverage cost.

REFUNDABLE TAX CREDITS (§§ 6-9)

The bill establishes refundable tax credits for small employers offering employees health insurance. The credits vary depending on the type of plan offered and who they cover (see below). The credits apply against any corporation and business entity taxes the employer owes. (The business entity tax applies to limited liability companies and similar entities.) To be eligible, an employer must (1) submit a copy of its health insurance plan to the Connector, (2) obtain a certificate of tax credit eligibility from the Connector, and (3) pay at least 70% of the employee coverage costs and 50% of the full-time employees' dependent coverage costs.

The bill requires the Connector to (1) determine whether to certify that an employer is eligible for a tax credit within 30 days of receiving all relevant information from the employer and (2) provide information to employers seeking certification assistance.

The bill authorizes an employer that is a limited liability company, limited liability partnership, limited partnership, or S corporation to distribute its available tax credit to its members, who may use the credit against any income tax they owe.

If the tax owed is less than the value of the tax credit, the state must refund any unused credit to the employer or member as appropriate. The bill requires the allowable credits to be indexed annually to the consumer price index for medical care.

The bill defines employer as any person, firm, business, educational institution, nonprofit agency, corporation, limited liability company, or any other entity that, on at least 50% of its working days during the last 12 months, employed 50 or fewer eligible employees, the majority in the state. It excludes the state and its political subdivisions. A “full-time employee” is a person an employer employs for 30 hours or more a week in a full-time position; a “part-time employee” is somebody employed for less than 30 hours a week in a part-time position.

Affordable Health Care Plan Tax Credit (§ 6)

The table below shows the annual per-employee tax credit for employers offering an affordable health care plan to all full-time employees but not all part-time employees.

<i>If the plan covers:</i>	<i>Then the credit equals:</i>
An employee	20% of the cost of providing health care benefits, up to \$800.
An employee and one other person	20% of the cost, up to \$1,600.
An employee and family	20% of the cost, up to \$2,400.

The table below shows the annual per-employee tax credit for employers offering an affordable health care plan to all full-time and part-time employees.

<i>If the plan covers:</i>	<i>Then the credit equals:</i>
An employee	25% of the cost of providing health care benefits, up to \$1,000.
An employee and one other person	25% of the cost, up to \$2,000.
An employee and family	25% of the cost, up to \$3,000.

Comprehensive Health Care Plan Tax Credit (§ 7)

The table below shows the annual per-employee tax credit for employers offering a comprehensive health care plan to all full-time employees but not all part-time employees.

<i>If the plan covers:</i>	<i>Then the credit equals:</i>
An employee	30% of the cost of providing health care benefits, up to \$1,200.
An employee and one other person	30% of the cost, up to \$2,400.
An employee and family	30% of the cost, up to \$3,600.

The table below shows the annual per-employee tax credit for employers offering a comprehensive health care plan to all full-time and part-time employees.

<i>If the plan covers:</i>	<i>Then the credit equals:</i>
An employee	35% of the cost of providing health care benefits, up to \$1,400.
An employee and one other person	35% of the cost, up to \$2,800.
An employee and family	35% of the cost, up to \$4,200.

State Employee Equivalent Plan Tax Credit (§ 8)

The table below shows the annual per-employee tax credit for

employers offering to all full-time employees but not all part-time employees a health care plan that meets or exceeds the minimum benefit plan provided to state employees pursuant to the State Employees' Bargaining Agent Coalition (SEBAC) agreement.

<i>If the plan covers:</i>	<i>Then the credit equals:</i>
An employee	40% of the cost of providing health care benefits, up to \$1,600.
An employee and one other person	40% of the cost, up to \$3,200.
An employee and family	40% of the cost, up to \$4,800.

The table below shows the annual per-employee tax credit for employers offering to all full-time and part-time employees a health care plan that meets or exceeds the minimum benefit plan provided to state employees pursuant to the SEBAC agreement.

<i>If the plan covers:</i>	<i>Then the credit equals:</i>
An employee	45% of the cost of providing health care benefits, up to \$1,800.
An employee and one other person	45% of the cost, up to \$3,600.
An employee and family	45% of the cost, up to \$5,400.

Appropriation (§ 40)

The bill appropriates \$1 million to the Insurance Department for Connecticut Connector start-up costs.

HEALTH SAVINGS ACCOUNT INCENTIVE PROGRAM (§ 10)

The bill establishes a health savings account (HSA) incentive program. To be eligible, a person must have a family income of up to 400% of the federal poverty level (FPL), a HSA, and a high-deductible plan. (FPL for 2007, as published in the Federal Register January 24,

2007, is \$10,210 for an individual. Thus, 400% is \$40,840.) The bill requires the Connector to (1) contribute to a resident's HSA an amount based on a sliding scale by January 30 of any year for which the person made certain minimum HSA contributions in the prior calendar year and (2) establish procedures for people to claim payments. The table below provides the contributions required, by family income.

Family Income = 200% or Less	
Family HSA Contribution	Connector Contribution
\$2,500 (individual)	\$500
\$3,750 (family of two)	\$1,000
\$5,000 (family of three or more)	\$1,500
Family Income = 200% to 300%	
Family HSA Contribution	Connector Contribution
\$2,500 (individual)	\$400
\$3,750 (family of two)	\$800
\$5,000 (family of three or more)	\$1,200
Family Income = 300% to 400%	
Family HSA Contribution	Connector Contribution
\$2,500 (individual)	\$300
\$3,750 (family of two)	\$600
\$5,000 (family of three or more)	\$900

The bill requires the amounts specified for family income (1) between 200% and 300% of FPL and (2) between 300% and 400% FPL to be indexed annually to the consumer price index for medical care. It

does not index the amounts specified for family income of 200% of FPL or less.

PREMIUM SUBSIDY PROGRAM (§ 11)

The bill establishes a premium subsidy program. To be eligible, a person must:

1. have family income of up to 400% of FPL;
2. not own an HSA either individually or as part of a family; and
3. have health care coverage through (a) an employer-sponsored plan for which the person annually pays at least \$500 in premiums if single and at least \$1,000 if covered by a family plan or (b) a nonemployer-based plan purchased through the individual market or the Connector. (A person could be both single and covered under a family plan if covering dependent children. Perhaps “single” means covered under an employee-only plan.)

The bill requires the Connector to (1) reimburse eligible people quarterly for premiums paid in the preceding quarter based on a sliding scale and (2) establish procedures by which eligible people may claim a premium subsidy.

For a family with income of 200% of FPL or less, the Connector must reimburse 80% of their premium share, up to \$125 per quarter for an individual, \$250 for an individual plus one dependent, or \$375 for a family.

For a family with income between 200% and 300% of FPL, the Connector must reimburse 60% of their premium share, up to \$100 per quarter for an individual, \$200 for an individual plus one dependent, or \$300 for a family.

For a family with income between 300% and 400% of FPL, the Connector must reimburse 40% of their premium share, up to \$75 per quarter for an individual, \$150 for an individual plus one dependent,

or \$225 for a family.

FEDERAL WAIVER TO OFFSET COSTS (§ 12)

The bill directs the DSS commissioner to request a federal waiver (presumably of Medicaid rules) to obtain federal reimbursement for (1) state expenditures related to the HSA incentive and premium assistance programs and (2) establishing a Medicaid-funded state excess cost reinsurance program for residents enrolled in the Connector's affordable health plan who exhaust their plan's coverage to ensure that they do not have to spend all their assets on health care once this occurs.

HEALTH INSURANCE CHANGES

Employer Plans for Low-Income Workers (§ 13)

The bill prohibits employers from offering health benefit plans to lower-paid employees that are of less value than those offered to higher-paid employees. It does not define "lower-paid" or "higher-paid."

Small Employer Case Characteristic for Rates (§ 22)

Under current law, insurers and HMOs must use adjusted community rating when developing premium rates for small employer groups. Community rating is the process of developing a uniform rate for all enrollees. An adjusted community rate is one that modifies the community rate by one or more classifications specified in statute.

The classifications allowed by law are age, gender, location, industry classification, group size, family composition, and administrative cost and profit reduction savings resulting from administering or writing an association group plan or a Municipal Employee Health Insurance Plan (MEHIP).

The bill changes the effective date of the adjusted community rating law to July 1, 2008 and adds smoking status as a classification that insurers and HMOs may consider when developing a small employer's policy rates. In effect, the bill eliminates the rating

requirement as of July 1, 2007 (the bill's effective date) and reinstates it July 1, 2008. (It is unclear what rating requirements insurers and HMOs are to follow until July 1, 2008.)

Dependent Age (§ 27)

The bill requires individual health insurance and HMO policies that cover dependent unmarried children to cover a child until he or she turns age 26. Current law requires coverage until age 19, or age 23 if the child is a full-time student at an accredited institution.

The dependent age provision applies to individual health insurance and HMO policies that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, (4) accidents, (5) limited benefits, and (6) hospital or medical services.

The bill does not change the dependent age for group comprehensive health care plans and plans continuing coverage after an employee's layoff, reduction of hours, leave of absence, or termination. For those plans, dependent age remains age 19, or age 23 if the child is a full-time student at an accredited institution.

Limited Health Benefit Plans (§§ 28 & 29)

Supplemental Coverage. The bill prohibits an insurer, HMO, or other entity issuing, renewing, continuing, or amending a health insurance policy beginning October 1, 2007 from issuing a limited benefit coverage policy (1) on an individual basis to any person unless the person signs a statement on the coverage application form confirming he or she is covered under another health benefit plan or (2) on a group basis unless each employee electing the coverage confirms in writing that he or she is covered under another health benefit contract.

It requires the employer offering the limited benefit plan to (1) have each employee electing the coverage sign a statement confirming coverage another plan and (2) submit the signed statements to the insurer, HMO, or other entity issuing the policy.

Conspicuous Statement. The bill requires each individual and group limited benefit coverage policy, contract, and certificate to include a conspicuous statement printed in capital letters and at least 12-point bold face type that says:

THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS.

Definition. The bill defines “limited benefit coverage” as an insurance policy that is designed, advertised, and marketed to supplement major medical insurance. It includes the following types of policies:

1. accident only;
2. dental only;
3. vision only;
4. disability income only;
5. fixed or hospital indemnity coverage;
6. specified disease insurance;
7. credit insurance;
8. Taft-Hartley trusts; and
9. those covering more than one disease or service but with a total coverage limit less than \$100,000 or a per service or condition coverage limit less than \$20,000.

TAX CHANGES***HMO Tax Reduction (§ 24)***

Under current law, HMOs pay an annual tax of 1.75% of their total net direct subscriber charges received during the calendar year on new and renewal contracts. Domestic and foreign (organized in another state) insurers similarly pay an annual premium tax of 1.75% per policy sold in Connecticut. The bill reduces the HMO tax from 1.75% to 1.5%.

By law, numerous contracts are exempt from the HMO tax, including contracts covering (1) state employees, (2) Medicare and Medicaid recipients, (3) retired teachers, (4) individuals eligible for a health coverage tax credit, and (5) municipal employees and retirees, (6) nonprofit employees, and (7) community action agency employees covered through MEHIP.

Health Club Sales Tax Exemption (§§ 25 & 26)

The bill repeals the sales tax on health club services. It also specifically exempts from sales taxes health and fitness center “dues and fees” paid for health benefit activities. (However, dues are not currently subject to sales tax. Rather, dues are subject to a separate 10% dues tax. Also, the bill does not define “health and fitness center” or “health benefit activities.”)

“Vanity Tax” Imposed (§ 25)

The bill imposes the sales tax on surgical and nonsurgical cosmetic medical procedures meant to improve appearance that do not (1) meaningfully promote proper body function or (2) prevent or treat illness or disease. The services subject to the tax include cosmetic surgery; hair transplants; cosmetic injections; cosmetic soft tissue fillers; dermabrasion and chemical peel; laser hair removal, skin resurfacing, and treatment of leg veins; sclerotherapy; and cosmetic dentistry. “Cosmetic surgery” means the surgical reshaping of normal body structures to improve a person’s body image, self-esteem, or appearance.

Under the bill, “cosmetic medical procedures” exclude reconstructive surgery or dentistry, including any (1) surgery or dentistry performed on abnormal structures caused by, or related to, congenital defects, developmental abnormalities, trauma, infection, tumors, or disease or (2) procedures to improve function or give a more normal appearance.

Cigarette Tax Increased (§ 34)

The bill increases the cigarette tax by 14 cents, from \$1.51 to \$1.65, per pack. (The bill does not impose the tax on a dealer’s inventory in stock on the day before the tax increase.)

HUSKY AND MEDICAID CHANGES

Increase in Income Limit for Adult Caretaker Relatives (§ 19)

The bill increases the HUSKY A income limit for adult caretaker relatives of children enrolled in HUSKY A from 150% to 185% of FPL. Children are already covered at 185% of FPL.

Increase in Income Limit for Medically Needy (§ 20)

The bill requires the DSS commissioner to file a Medicaid state plan amendment to increase the income limit for medically needy coverage from 143% of cash welfare benefits to 150% of the FPL. (The medically needy include aged, blind, and disabled individuals and certain others not covered under other Medicaid categories.) For a one-person household, this would increase the limit from \$476 per month to \$1,276 per month. (As the income limit is set in federal law, it appears that DSS cannot increase it with a state plan amendment, but it can use an amendment to increase the amount of unearned income it disregards in determining eligibility, which would have the same effect.)

Increasing the income limit for the medically needy program will reduce, if not eliminate, the amount of excess income applicants must spend on medical bills before qualifying for assistance.

Continuous Eligibility in HUSKY (§§ 21 & 41)

The bill restores continuous eligibility (CE) for children enrolled in

HUSKY A or B and extends it to adults eligible for HUSKY A. (PA 03-2 eliminated it.) Under the bill, CE allows enrollees to receive ongoing assistance for 12 months even if the parent's or caretaker's financial circumstances change during that time. The CE of both is contingent on the child being under age 19 and a state resident. During this period of CE, the family must comply with federal requirements for reporting information to DSS, such as a change of address.

The bill makes a corollary change by repealing a separate provision that prohibits adults enrolled in Medicaid from being guaranteed eligibility for six months without regard to changes in circumstances that would otherwise render them ineligible. (It does not appear that federal law allows CE for adults, so federal reimbursement may not be possible in these cases.)

Automatic HUSKY B Enrollment of Uninsured Newborns (§ 21)

The bill requires that any uninsured child born in a Connecticut hospital or an "eligible border state hospital" be enrolled in HUSKY B under an expedited process when (1) the child's family lives in Connecticut and (2) at least one parent authorizes the enrollment. It requires the DSS commissioner to pay to the HUSKY B managed care organization (MCO) the family chooses the first two month's premium the family would otherwise have to pay. Currently, families with incomes between 235% and 300% of FPL pay \$30 per month (\$50 family maximum) in premiums. Lower income families do not pay premiums.

10% Limit on MCO Administrative Costs (§ 16)

Starting July 1, 2007, the bill requires any MCO entering into, renewing, or amending a HUSKY contract to limit its administrative costs to 10% or less of its capitated payments (amount state pays MCO to serve HUSKY clients).

In defining the administrative costs, the bill allows the commissioner to exclude disease management or other value-added clinical programs that the MCOs administer. But he may not exclude

any utilization management, claims, member services, or other nonclinical functions.

The DSS commissioner must implement this change while in the process of adopting it in regulation, provided he publishes notice of intent to adopt the regulations in the *Connecticut Law Journal* within 20 days after implementing it. The policies and procedures are valid until the regulations become effective.

Increases in Reimbursements to Providers (§§ 17 & 38)

The bill requires the DSS commissioner to increase the fee-for-service (FFS) Medicaid reimbursement rates for physicians, dentists, and hospitals starting July 1, 2007. The following table shows the rate increases and inflationary adjustments.

<i>Provider/Service</i>	<i>FY 08 Increase</i>	<i>Annual Adjustment</i>
Dental services	60%	Consumer price index for medical care
Physicians	To 80% of aggregate Medicare rates	Maintain 80% of aggregate Medicare rates
Hospital services	To 90% of aggregate Medicare rates	Maintain 90% of aggregate Medicare rates

The bill also requires the commissioner, on July 1, 2007, to amend each managed care contract it maintains, on renewal, to require the MCOs to increase reimbursements to at least the levels required for the FFS providers. (It is unclear whether July 1, 2007 is the same as the MCO renewal date.)

The bill appropriates an unspecified amount to DSS from the General Fund for FY 08 to carry out this section.

Outreach (§§ 18 & 39)

The bill requires the DSS commissioner to award 50 grants of up to

\$10,000 each to community-based organizations for public education, outreach, and recruitment of HUSKY-eligible children, including distributing applications and enrollment information. It appropriates \$500,000 to DSS from the General Fund for FY 08 for the grants.

Primary Care Case Management (§ 14)

The bill requires the DSS commissioner to develop a plan to implement a primary care case management (PCCM) program for some or all Medicaid recipients who are aged, blind, or disabled. The commissioner can contract with an administrative services organization to run the program. The plan must include programs to improve medical service coordination and chronic disease management. It must also include predictive modeling for identifying high-risk, complex, and high-cost Medicaid beneficiaries and providing them with intensive care coordination.

Under the PCCM model, a beneficiary chooses a primary care provider who is responsible for coordinating the person's care. The provider is paid a separate fee above the regular fees paid for providing direct medical service.

Allowing Aged, Blind, and Disabled Beneficiaries to Voluntarily Enroll in Managed Care (§ 15)

Beginning January 1, 2008, the bill requires the DSS commissioner to allow aged, blind, or disabled Medicaid beneficiaries to enroll in the MCOs available to HUSKY beneficiaries. (Presumably, beneficiaries would choose between PCCM- or MCO-based care.)

STATE-ADMINISTERED GENERAL ASSISTANCE (SAGA) (§ 33)

On July 1, 2007, the bill increases by at least 5% the amount that DSS (or the MCO contracting with it to administer the program) must pay federally qualified health centers (FQHC) and other primary care providers serving SAGA medical assistance recipients. In subsequent fiscal years, this amount must increase by at least the percentage increase in the consumer price index.

The bill also eliminates the requirement that DSS make payments to

these providers within available appropriations. In practice, FQHCs and other primary care providers (used when an FQHC is not feasible) must currently take any SAGA patients referred to them, regardless of whether state funding for them is sufficient.

PUBLIC HEALTH CHANGES AND PROGRAMS

Smoking Cessation Program (§ 23)

The bill establishes, within existing appropriations, a smoking cessation program known as “Quit for Good.” It is administered by the Department of Public Health (DPH), which must contract with one or more entities for implementation. The program must (1) promote smoking cessation among unserved and underserved people, (2) educate the public on the health complications of smoking and ways of quitting, (3) provide counseling and treatment referral services, and (4) establish a system for tracking and monitoring those receiving program smoking cessation assistance.

The bill defines “unserved or underserved populations” as those at or below 200% of FPL who do not have health insurance that comprehensively covers smoking cessation.

Commission on Healthy Lifestyles (§ 30)

The bill establishes a 14-member permanent Commission on Healthy Lifestyles as an independent body in OHCA for administrative purposes only. By October 1, 2007, it must (1) develop a marketing campaign educating the public on basic ways to ensure good health and the consequences of poor health and (2) make recommendations to the General Assembly on incentives encouraging personal responsibility in making healthy lifestyle choices.

Commission members include the DPH, DSS, OHCA, education, and insurance commissioners and nine appointed members. The Senate president pro tempore and the House speaker each appoint two and the governor, House and Senate majority leaders, and House and Senate minority leaders each appoint one.

The initial members serve staggered terms with (1) the governor’s

and Senate president pro tempore's appointees serving for three years, (2) the House speaker's and Senate majority leader's appointees for two years, and (3) the remaining members for one year. After the initial terms expire, subsequent appointees serve three-year terms. Any vacancy must be filled by the appointing authority for the unexpired term. Members are not compensated but are reimbursed for their duties. (This creates a conflict since "reimbursed for duties" is compensation.)

The bill requires the commission to meet at least quarterly and allows it to hire consultants within available appropriations. OHCA must, within available appropriations, contract with one or more entities to implement the required marketing campaign.

Limits on Physician and Hospital Fees (§ 32)

The bill prohibits physicians or hospitals that (1) do not have a contract with a third-party payer or (2) provide medical services to people without health insurance coverage from charging fees for such services that exceed 200% of the fees allowed by Medicare.

Connecticut's Uninsured (§ 35)

Beginning October 1, 2007 and every five years afterward, OHCA must determine the number of uninsured Connecticut residents. The bill requires the Health Care Reform Commission to determine whether residents should be required to have health insurance if the number of uninsured has not decreased by 50% by October 1, 2012. By January 1, 2013, the commission must report its findings to the Insurance and Real Estate Committee.

By December 31, 2007 and annually afterwards, OHCA must conduct a survey to determine the number of Connecticut employers providing health insurance to their employees residing in Connecticut. OHCA must annually report its findings to the Insurance and Real Estate Committee beginning January 1, 2008.

Tobacco and Health Trust Fund (§ 36)

The bill requires the remaining Tobacco and Health Trust Fund

money to be transferred to the General Fund. It requires DPH to use \$20 million of that amount for the Smoke-Free Connecticut Program.

DPH Appropriation (§ 37)

The bill appropriates \$1.6 million to DPH from the General Fund for FY 08 to provide grants of \$200,000 to each of eight different groups representing employers. These grants must be used to train employers to educate employees on the financial and health benefits of making lifestyle choices promoting good health, including regular exercise and maintaining a healthy weight.

BACKGROUND

Legislative History

The House referred the bill (File 219) to the Public Health Committee, which reported it favorably. The House then referred the bill to the Appropriations Committee, which reported a substitute bill favorably. The substitute bill deletes the requirement that providers accept and provide services to anyone enrolled in HUSKY and Medicaid.

Related Bills

Several legislative committees have favorably reported bills broadly addressing health care access. They are:

<i>Bill No.</i>	<i>Committee</i>	<i>File No.</i>
sSB 1	Public Health	472
sSB 3	Human Services	345
SB 70	Insurance	106
SB 1127	Human Services	685
sSB 1371	Insurance	233
sHB 6158	Children	246

sHB 7314	Labor	264
sHB 7320	Labor	780
sHB 7375	Human Services	296
sHB 7396	Appropriations	784

In addition, several committees have reported bills that have provisions similar or related to specific sections of sHB 6652. They are:

Bill No.	Committee	File No.	Provision
SB 250	Insurance	78	Cost-benefit study of mandated health insurance benefits
HB 5496	Insurance	243	Limited benefit health plans
HB 6055	Insurance, Appropriations	245, 772	Dependent age
sHB 7055	Insurance	48, 796	Medically necessary definition
sHB 7069	Public Health	478	Medicaid dental rates

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 18 Nay 1 (03/13/2007)

Public Health Committee

Joint Favorable

Yea 28 Nay 0 (04/20/2007)

Appropriations Committee

Joint Favorable Substitute

Yea 29 Nay 11 (04/30/2007)