



House of Representatives

General Assembly

File No. 896

January Session, 2007

Substitute House Bill No. 6652

House of Representatives, May 31, 2007

The Committee on Finance, Revenue and Bonding reported through REP. STAPLES of the 96th 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, (2) not later than
34 July 1, 2008, develop a comprehensive health care plan, as described in
35 section 38a-555 of the general statutes, that an employer of fifty or
36 fewer employees shall make available to employees, (3) not later than
37 January 1, 2009, submit a report to the joint standing committee of the
38 General Assembly having cognizance of matters relating to insurance
39 that identifies the effect of health insurance mandates under chapter
40 700c of the general statutes on health care premiums paid by private
41 sector employers, (4) develop incentives to encourage individuals to
42 use health insurance responsibly, (5) develop a proposed plan and
43 timetable for the implementation of state-wide electronic prescribing,
44 computerized physician order entry in every hospital, and a uniform
45 electronic medical record system that will improve the quality of
46 health care in the state, (6) plan for the implementation of a
47 pharmaceutical purchasing pool to be administered by a third-party

48 administrator to cover all public employees and public programs, (7)
49 establish the Connecticut Health Quality Partnership under section 24
50 of this act, (8) perform the duties as required under section 26 of this
51 act, and (9) not later than January 1, 2009, and annually thereafter,
52 make recommendations to the General Assembly concerning the
53 implementation of the Connecticut Healthy Steps Program and
54 improvements to the health care system, including cost controls.

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

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

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

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

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

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

76 (3) Publish easy to understand materials for prospective purchasers,
77 comparing the costs and benefits of all plans and providing counseling
78 to assist in plan selection;

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

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

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

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

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

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

97 (10) Market the health plans available through the Connecticut
98 Connector to potential purchasers of the health plans;

99 (11) Receive moneys from the Comptroller and make payments to
100 eligible individuals and employers in accordance with sections 6 and 7
101 of this act;

102 (12) Not later than July 1, 2009, and annually thereafter, provide
103 data and reports to the Health Care Reform Commission and the
104 General Assembly, which shall include, but not be limited to (A) the
105 number and demographics of previously uninsured persons covered
106 through the Connecticut Connector by type of policy, (B) the per capita
107 administrative costs of the Connecticut Connector, (C) any
108 recommendations for improving service, health insurance policy

109 offerings and costs, and (D) any other information as required by said
110 commission.

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

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

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

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

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

129 (4) A lifetime benefits maximum in the amount of five hundred
130 thousand dollars, contingent upon the availability of an excess cost
131 reinsurance program through the Department of Social Services for
132 which an individual or family would become eligible without
133 spending down all of their resources upon exhaustion of their
134 insurance benefit; and

135 (5) A minimum loss ratio of not less than eighty-five per cent over
136 any three-year moving average period.

137 (c) Each health care plan offered shall:

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

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

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

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

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

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

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

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

161 (A) Loss of coverage through the employer, due to termination of
162 employment;

163 (B) Death of, or abandonment by, a family member who previously
164 provided coverage;

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

167 (D) Disqualification as a dependent under a group comprehensive
168 health care plan;

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

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

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

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

179 (1) Has fifty or fewer employees;

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

182 (3) Will contribute a minimum of seventy per cent of the cost of such
183 coverage for an employee and a minimum of fifty per cent of the cost
184 of dependent coverage for any dependent of such employee.

185 Sec. 6. (NEW) (*Effective July 1, 2007*) (a) There is established the
186 health savings account incentive program. To be eligible for payment
187 pursuant to this section, an individual's family income may not exceed
188 four hundred per cent of the federal poverty level. The Connecticut
189 Connector shall annually contribute to the health savings account of
190 any individual who resides in the state and who has a health savings
191 account and high deductible health plan pursuant to section 223 of the
192 Internal Revenue Code of 1986, or any subsequent corresponding
193 internal revenue code of the United States, as from time to time
194 amended, an amount determined by a sliding scale as follows:

195 (1) For a family income equal to or less than two hundred per cent

196 of the federal poverty level, five hundred dollars for an individual who
197 has contributed or received contributions of at least two thousand five
198 hundred dollars in his or her health savings account in the previous
199 year, one thousand dollars for a family of two who has contributed or
200 received contributions of at least three thousand seven hundred fifty
201 dollars in their health savings account in the previous year, or one
202 thousand five hundred dollars for a family of three or more who has
203 contributed or received contributions of at least five thousand dollars
204 in their health savings account in the previous year.

205 (2) For a family income greater than two hundred per cent but less
206 than three hundred per cent of the federal poverty level, four hundred
207 dollars for an individual who has contributed or received
208 contributions of at least two thousand five hundred dollars in his or
209 her health savings account in the previous year, eight hundred dollars
210 for a family of two who has contributed or received contributions of at
211 least three thousand seven hundred fifty dollars in their health savings
212 account in the previous year, or one thousand two hundred dollars for
213 a family of three or more who has contributed or received
214 contributions of at least five thousand dollars in their health savings
215 account in the previous year.

216 (3) For a family income equal to or greater than three hundred per
217 cent but less than four hundred per cent of the federal poverty level,
218 three hundred dollars for an individual who has contributed or
219 received contributions of at least two thousand five hundred dollars in
220 his or her health savings account in the previous year, six hundred
221 dollars for a family of two who has contributed or received
222 contributions of at least three thousand seven hundred fifty dollars in
223 their health savings account in the previous year, or nine hundred
224 dollars for a family of three or more who has contributed or received
225 contributions of at least five thousand dollars in their health savings
226 account in the previous year.

227 (b) The amounts specified in subdivisions (2) and (3) of subsection
228 (a) of this section shall be annually indexed to the consumer price

229 index for medical care.

230 (c) The Connecticut Connector shall make payments, in accordance
231 with this section, by January thirtieth of any year for health savings
232 account contributions in the prior calendar year. The Connecticut
233 Connector shall establish procedures by which individuals may claim
234 payment pursuant to this section.

235 Sec. 7. (NEW) (*Effective July 1, 2007*) (a) There is established the
236 premium subsidy program. To be eligible for payment pursuant to this
237 section, an individual (1) shall not have family income exceeding four
238 hundred per cent of the federal poverty level, (2) shall not individually
239 or as part of a family own a health savings account pursuant to section
240 223 of the Internal Revenue Code of 1986, or any subsequent
241 corresponding internal revenue code of the United States, as from time
242 to time amended, and (3) shall have health care coverage under an
243 employer-sponsored plan for which the employee pays at least five
244 hundred dollars in premiums annually to the employee's employer if
245 single and at least one thousand dollars in premiums annually to the
246 employee's employer if the employee is covered by a family plan or
247 has a nonemployer-based plan purchased through the individual
248 market or the Connecticut Connector. The Connecticut Connector shall
249 quarterly reimburse an individual who is eligible pursuant to this
250 section for premiums paid in the preceding quarter as follows:

251 (A) For a family with income equal to or less than two hundred per
252 cent of the federal poverty level, eighty per cent of their share of the
253 premium, not to exceed one hundred twenty-five dollars per quarter
254 for an individual, two hundred fifty dollars per quarter for an
255 individual plus one dependent, or three hundred seventy-five dollars
256 per quarter for a family.

257 (B) For a family with income greater than two hundred per cent but
258 less than three hundred per cent of the federal poverty level, sixty per
259 cent of their share of the premium, not to exceed one hundred dollars
260 per quarter for an individual, two hundred dollars per quarter for an
261 individual plus one dependent, or three hundred dollars per quarter

262 for a family.

263 (C) For a family with income greater than three hundred per cent
264 but less than four hundred per cent of the federal poverty level, forty
265 per cent of their share of the premium, not to exceed seventy-five
266 dollars per quarter for an individual, one hundred fifty dollars per
267 quarter for an individual plus one dependent, or two hundred twenty-
268 five dollars per quarter for a family.

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

271 Sec. 8. (NEW) (*Effective July 1, 2007*) The Commissioner of Social
272 Services shall seek a federal waiver for the purpose of (1) obtaining any
273 available federal reimbursement for state expenditures related to the
274 health savings account incentive program established under section 6
275 of this act and the subsidized premium program established under
276 section 7 of this act, and (2) establishing a state excess cost reinsurance
277 program for enrollees in the Connecticut Connector's affordable health
278 care plan to allow such enrollees to obtain coverage through the
279 Medicaid program once their insurance benefits are exhausted without
280 having to spend down their assets.

281 Sec. 9. (NEW) (*Effective July 1, 2007*) No employer in this state may
282 offer health benefit plans of lesser value to lower-paid employees than
283 to higher-paid employees.

284 Sec. 10. (NEW) (*Effective July 1, 2007*) The Commissioner of Social
285 Services shall develop a plan to implement a system of primary care
286 case management for the delivery of health care services to all or a
287 substantial subset of the aged, blind and disabled Medicaid
288 beneficiaries. Said commissioner may contract with an administrative
289 services organization to effectuate the implementation of such primary
290 care case management system. Such plan shall include programs to
291 improve coordination of and access to medical services, chronic
292 disease management programs, predictive modeling to identify high
293 risk, complex and high-cost Medicaid beneficiaries and to provide

294 them with intensive care coordination.

295 Sec. 11. (NEW) (*Effective July 1, 2007*) On and after January 1, 2008,
296 the Commissioner of Social Services shall allow aged, blind or disabled
297 Medicaid beneficiaries to voluntarily enroll in the managed care plans
298 available to HUSKY Plan, Part A and HUSKY Plan, Part B
299 beneficiaries.

300 Sec. 12. Section 17b-267 of the general statutes is repealed and the
301 following is substituted in lieu thereof (*Effective July 1, 2007*):

302 (a) If any group or association of providers of medical assistance
303 services wishes to have payments as provided for under sections 17b-
304 260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to
305 17b-361, inclusive, to such providers made through a national, state or
306 other public or private agency or organization and nominates such
307 agency or organization for this purpose, the Commissioner of Social
308 Services is authorized to enter into an agreement with such agency or
309 organization providing for the determination by such agency or
310 organization, subject to such review by the Commissioner of Social
311 Services as may be provided for by the agreement, of the payments
312 required to be made to such providers at the rates set by the hospital
313 cost commission, and for the making of such payments by such agency
314 or organization to such providers. Such agreement may also include
315 provision for the agency or organization to do all or any part of the
316 following: With respect to the providers of services which are to
317 receive payments through it, (1) to serve as a center for, and to
318 communicate to providers, any information or instructions furnished
319 to it by the Commissioner of Social Services, and to serve as a channel
320 of communication from providers to the Commissioner of Social
321 Services; (2) to make such audits of the records of providers as may be
322 necessary to insure that proper payments are made under this section;
323 and (3) to perform such other functions as are necessary to carry out
324 the provisions of sections 17b-267 to 17b-271, inclusive.

325 (b) The Commissioner of Social Services shall not enter into an
326 agreement with any agency or organization under subsection (a) of

327 this section unless (1) he finds (A) that to do so is consistent with the
328 effective and efficient administration of the medical assistance
329 program, and (B) that such agency or organization is willing and able
330 to assist the providers to which payments are made through it in the
331 application of safeguards against unnecessary utilization of services
332 furnished by them to individuals entitled to hospital insurance benefits
333 under section 17b-261 and the agreement provides for such assistance,
334 and (2) such agency or organization agrees to furnish to the
335 Commissioner of Social Services such of the information acquired by it
336 in carrying out its agreement under sections 17b-267 to 17b-271,
337 inclusive, as the Commissioner of Social Services may find necessary in
338 performing his functions under said sections.

339 (c) An agreement with any agency or organization under subsection
340 (a) of this section may contain such terms and conditions as the
341 Commissioner of Social Services finds necessary or appropriate, may
342 provide for advances of funds to the agency or organization for the
343 making of payments by it under said subsection (a), and shall provide
344 for payment by the Commissioner of Social Services of so much of the
345 cost of administration of the agency or organization as is determined
346 by the Commissioner of Social Services to be necessary and proper for
347 carrying out the functions covered by the agreement.

348 (d) On or after July 1, 2007, each managed care plan that enters into,
349 renews or amends a contract with the Department of Social Services
350 pursuant to this section shall limit its administrative costs to ten per
351 cent of payments made pursuant to such contracts. The Commissioner
352 of Social Services shall implement policies and procedures to effectuate
353 the purposes of this subsection while in the process of adopting such
354 policies or procedures in regulation form, provided notice of intention
355 to adopt the regulations is printed in the Connecticut Law Journal not
356 later than twenty days after implementation of such policies and
357 procedures and any such policies and procedures shall be valid until
358 the time the regulations are effective. The Commissioner of Social
359 Services may define administrative costs to exclude disease
360 management or other value-added clinical programs administered by

361 the managed care plans, but not to exclude utilization management,
362 claims, member services or other nonclinical functions.

363 Sec. 13. (NEW) (*Effective July 1, 2007*) (a) On July 1, 2007, the
364 Commissioner of Social Services shall increase the fee-for-service
365 Medicaid reimbursement rates for (1) dental services by sixty per cent,
366 (2) physician services to a level equivalent to at least eighty per cent of
367 Medicare rates in aggregate, and (3) hospital services to a level
368 equivalent to at least ninety per cent of Medicare rates in aggregate.
369 The rates of reimbursement to be paid to dentists under the fee-for-
370 service program shall be annually increased to reflect increases in the
371 consumer price index for medical care. The rates of reimbursement to
372 be paid to physicians and hospitals shall be annually increased to
373 remain at such percentage of Medicare rates.

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

380 Sec. 14. Section 17b-297 of the general statutes is repealed and the
381 following is substituted in lieu thereof (*Effective July 1, 2007*):

382 (a) The commissioner, in consultation with the Children's Health
383 Council, the Medicaid Managed Care Council and Infoline of
384 Connecticut, shall develop mechanisms for outreach for the HUSKY
385 Plan, Part A and Part B, including, but not limited to, development of
386 mail-in applications and appropriate outreach materials through the
387 Department of Revenue Services, the Labor Department, the
388 Department of Social Services, the Department of Public Health, the
389 Department of Children and Families and the Office of Protection and
390 Advocacy for Persons with Disabilities.

391 (b) The commissioner shall include in such outreach efforts
392 information on the Medicaid program for the purpose of maximizing

393 enrollment of eligible children and the use of federal funds.

394 (c) The commissioner shall, within available appropriations,
395 contract with severe need schools and community-based organizations
396 for purposes of public education, outreach and recruitment of eligible
397 children, including the distribution of applications and information
398 regarding enrollment in the HUSKY Plan, Part A and Part B. In
399 awarding such contracts, the commissioner shall consider the
400 marketing, outreach and recruitment efforts of organizations. For the
401 purposes of this subsection, (1) "community-based organizations" shall
402 include, but not be limited to, day care centers, schools, school-based
403 health clinics, community-based diagnostic and treatment centers and
404 hospitals, and (2) "severe need school" means a school in which forty
405 per cent or more of the lunches served are served to students who are
406 eligible for free or reduced price lunches.

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

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

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

420 Sec. 15. Subsection (a) of section 17b-261 of the general statutes is
421 repealed and the following is substituted in lieu thereof (*Effective July*
422 *1, 2007*):

423 (a) Medical assistance shall be provided for any otherwise eligible

424 person whose income, including any available support from legally
425 liable relatives and the income of the person's spouse or dependent
426 child, is not more than one hundred forty-three per cent, pending
427 approval of a federal waiver applied for pursuant to subsection (d) of
428 this section, of the benefit amount paid to a person with no income
429 under the temporary family assistance program in the appropriate
430 region of residence and if such person is an institutionalized
431 individual as defined in Section 1917(c) of the Social Security Act, 42
432 USC 1396p(c), and has not made an assignment or transfer or other
433 disposition of property for less than fair market value for the purpose
434 of establishing eligibility for benefits or assistance under this section.
435 Any such disposition shall be treated in accordance with Section
436 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
437 property made on behalf of an applicant or recipient or the spouse of
438 an applicant or recipient by a guardian, conservator, person
439 authorized to make such disposition pursuant to a power of attorney
440 or other person so authorized by law shall be attributed to such
441 applicant, recipient or spouse. A disposition of property ordered by a
442 court shall be evaluated in accordance with the standards applied to
443 any other such disposition for the purpose of determining eligibility.
444 The commissioner shall establish the standards for eligibility for
445 medical assistance at one hundred forty-three per cent of the benefit
446 amount paid to a family unit of equal size with no income under the
447 temporary family assistance program in the appropriate region of
448 residence, pending federal approval, except that the medical assistance
449 program shall provide coverage to persons under the age of nineteen
450 up to one hundred eighty-five per cent of the federal poverty level
451 without an asset limit. Said medical assistance program shall also
452 provide coverage to persons under the age of nineteen and their
453 parents and needy caretaker relatives who qualify for coverage under
454 Section 1931 of the Social Security Act with family income up to one
455 hundred [fifty] eighty-five per cent of the federal poverty level without
456 an asset limit, upon the request of such a person or upon a
457 redetermination of eligibility. Such levels shall be based on the
458 regional differences in such benefit amount, if applicable, unless such

459 levels based on regional differences are not in conformance with
460 federal law. Any income in excess of the applicable amounts shall be
461 applied as may be required by said federal law, and assistance shall be
462 granted for the balance of the cost of authorized medical assistance. All
463 contracts entered into on and after July 1, 1997, pursuant to this section
464 shall include provisions for collaboration of managed care
465 organizations with the Nurturing Families Network established
466 pursuant to section 17a-56. The Commissioner of Social Services shall
467 provide applicants for assistance under this section, at the time of
468 application, with a written statement advising them of (1) the effect of
469 an assignment or transfer or other disposition of property on eligibility
470 for benefits or assistance, and (2) the availability of, and eligibility for,
471 services provided by the Nurturing Families Network established
472 pursuant to section 17a-56.

473 Sec. 16. Section 17b-261 of the general statutes is amended by
474 adding subsection (k) as follows (*Effective July 1, 2007*):

475 (NEW) (k) The Commissioner of Social Services, pursuant to 42 USC
476 1396a(r)(2), shall file an amendment to the Medicaid state plan to allow
477 the commissioner, when making Medicaid eligibility determinations,
478 to raise the medically needy income limit for persons who are aged,
479 blind or disabled to an amount not to exceed one hundred fifty per
480 cent of the federal poverty level.

481 Sec. 17. Section 17b-292 of the general statutes is repealed and the
482 following is substituted in lieu thereof (*Effective July 1, 2007*):

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

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

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

494 (d) A child or adult who has been determined to be eligible for
495 benefits under either the HUSKY Plan, Part A or Part B shall remain
496 eligible for such plan for a period of twelve months from such child's
497 determination of eligibility unless the child attains the age of nineteen
498 or is no longer a resident of the state. During the twelve-month period
499 following the date that a child is determined eligible for the HUSKY
500 Plan, Part A or Part B, the family of such child shall comply with
501 federal requirements concerning the reporting of information to the
502 department, including, but not limited to, change of address
503 information.

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

508 ~~[(e)]~~ (f) A newborn child who otherwise meets the eligibility criteria
509 for the HUSKY Plan, Part B shall be eligible for benefits retroactive to
510 his date of birth, provided an application is filed on behalf of the child
511 ~~[within]~~ not later than thirty days ~~[of]~~ after such date. Any uninsured
512 child born in a hospital in this state or in an eligible border state
513 hospital shall be enrolled by an expedited process in the HUSKY Plan,
514 Part B provided (1) the child's family resides in this state, and (2) a
515 parent of such child authorizes enrollment in the program. The
516 commissioner shall pay any premium cost such family would
517 otherwise incur for the first two months of coverage to the managed
518 care organization selected by the family to provide coverage for such
519 child.

520 ~~[(f)]~~ (g) The commissioner shall implement presumptive eligibility
521 for children applying for Medicaid. Such presumptive eligibility
522 determinations shall be in accordance with applicable federal law and
523 regulations. The commissioner shall adopt regulations, in accordance

524 with chapter 54, to establish standards and procedures for the
525 designation of organizations as qualified entities to grant presumptive
526 eligibility. Qualified entities shall ensure that, at the time a
527 presumptive eligibility determination is made, a completed application
528 for Medicaid is submitted to the department for a full eligibility
529 determination. In establishing such standards and procedures, the
530 commissioner shall ensure the representation of state-wide and local
531 organizations that provide services to children of all ages in each
532 region of the state.

533 [(g)] (h) The commissioner shall enter into a contract with an entity
534 to be a single point of entry servicer for applicants and enrollees under
535 the HUSKY Plan, Part A and Part B. The servicer shall jointly market
536 both Part A and Part B together as the HUSKY Plan. Such servicer shall
537 develop and implement public information and outreach activities
538 with community programs. Such servicer shall electronically transmit
539 data with respect to enrollment and disenrollment in the HUSKY Plan,
540 Part B to the commissioner.

541 [(h)] (i) Upon the expiration of any contractual provisions entered
542 into pursuant to subsection [(g)] (h) of this section, the commissioner
543 shall develop a new contract for single point of entry services and
544 managed care enrollment brokerage services. The commissioner may
545 enter into one or more contractual arrangements for such services for a
546 contract period not to exceed seven years. Such contracts shall include
547 performance measures, including, but not limited to, specified time
548 limits for the processing of applications, parameters setting forth the
549 requirements for a completed and reviewable application and the
550 percentage of applications forwarded to the department in a complete
551 and timely fashion. Such contracts shall also include a process for
552 identifying and correcting noncompliance with established
553 performance measures, including sanctions applicable for instances of
554 continued noncompliance with performance measures.

555 [(i)] (j) The single point of entry servicer shall send an application
556 and supporting documents to the commissioner for determination of

557 eligibility of a child who resides in a household with a family income
558 of one hundred eighty-five per cent or less of the federal poverty level.
559 The servicer shall enroll eligible beneficiaries in the applicant's choice
560 of managed care plan. Upon enrollment in a managed care plan, an
561 eligible HUSKY Plan, Part A or Part B beneficiary shall remain
562 enrolled in such managed care plan for twelve months from the date of
563 such enrollment unless (1) an eligible beneficiary demonstrates good
564 cause to the satisfaction of the commissioner of the need to enroll in a
565 different managed care plan, or (2) the beneficiary no longer meets
566 program eligibility requirements.

567 [(j)] (k) Not more than twelve months after the determination of
568 eligibility for benefits under the HUSKY Plan, Part A and Part B and
569 annually thereafter, the commissioner or the servicer, as the case may
570 be, shall determine if the child continues to be eligible for the plan. The
571 commissioner or the servicer shall mail an application form to each
572 participant in the plan for the purposes of obtaining information to
573 make a determination on eligibility. To the extent permitted by federal
574 law, in determining eligibility for benefits under the HUSKY Plan, Part
575 A or Part B with respect to family income, the commissioner or the
576 servicer shall rely upon information provided in such form by the
577 participant unless the commissioner or the servicer has reason to
578 believe that such information is inaccurate or incomplete. The
579 Department of Social Services shall annually review a random sample
580 of cases to confirm that, based on the statistical sample, relying on such
581 information is not resulting in ineligible clients receiving benefits
582 under HUSKY Plan, Part A or Part B. The determination of eligibility
583 shall be coordinated with health plan open enrollment periods.

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

587 [(l)] (m) The commissioner shall adopt regulations, in accordance
588 with chapter 54, to establish residency requirements and income
589 eligibility for participation in the HUSKY Plan, Part B and procedures

590 for a simplified mail-in application process. Notwithstanding the
591 provisions of section 17b-257b, such regulations shall provide that any
592 child adopted from another country by an individual who is a citizen
593 of the United States and a resident of this state shall be eligible for
594 benefits under the HUSKY Plan, Part B upon arrival in this state.

595 Sec. 18. Section 38a-567 of the general statutes is repealed and the
596 following is substituted in lieu thereof (*Effective July 1, 2007*):

597 Health insurance plans and insurance arrangements covering small
598 employers and insurers and producers marketing such plans and
599 arrangements shall be subject to the following provisions:

600 (1) (A) Any such plan or arrangement shall be renewable with
601 respect to all eligible employees or dependents at the option of the
602 small employer, policyholder or contract-holder, as the case may be,
603 except: (i) For nonpayment of the required premiums by the small
604 employer, policyholder or contract-holder; (ii) for fraud or
605 misrepresentation of the small employer, policyholder or
606 contractholder or, with respect to coverage of individual insured, the
607 insureds or their representatives; (iii) for noncompliance with plan or
608 arrangement provisions; (iv) when the number of insureds covered
609 under the plan or arrangement is less than the number of insureds or
610 percentage of insureds required by participation requirements under
611 the plan or arrangement; or (v) when the small employer, policyholder
612 or contractholder is no longer actively engaged in the business in
613 which it was engaged on the effective date of the plan or arrangement.

614 (B) Renewability of coverage may be effected by either continuing in
615 effect a plan or arrangement covering a small employer or by
616 substituting upon renewal for the prior plan or arrangement the plan
617 or arrangement then offered by the carrier that most closely
618 corresponds to the prior plan or arrangement and is available to other
619 small employers. Such substitution shall only be made under
620 conditions approved by the commissioner. A carrier may substitute a
621 plan or arrangement as stated above only if the carrier effects the same
622 substitution upon renewal for all small employers previously covered

623 under the particular plan or arrangement, unless otherwise approved
624 by the commissioner. The substitute plan or arrangement shall be
625 subject to the rating restrictions specified in this section on the same
626 basis as if no substitution had occurred, except for an adjustment
627 based on coverage differences.

628 (C) Notwithstanding the provisions of this subdivision, any such
629 plan or arrangement, or any coverage provided under such plan or
630 arrangement may be rescinded for fraud, material misrepresentation
631 or concealment by an applicant, employee, dependent or small
632 employer.

633 (D) Any individual who was not a late enrollee at the time of his or
634 her enrollment and whose coverage is subsequently rescinded shall be
635 allowed to reenroll as of a current date in such plan or arrangement
636 subject to any preexisting condition or other provisions applicable to
637 new enrollees without previous coverage. On and after the effective
638 date of such individual's reenrollment, the small employer carrier may
639 modify the premium rates charged to the small employer for the
640 balance of the current rating period and for future rating periods, to
641 the level determined by the carrier as applicable under the carrier's
642 established rating practices had full, accurate and timely underwriting
643 information been supplied when such individual initially enrolled in
644 the plan. The increase in premium rates allowed by this provision for
645 the balance of the current rating period shall not exceed twenty-five
646 per cent of the small employer's current premium rates. Any such
647 increase for the balance of said current rating period shall not be
648 subject to the rate limitation specified in subdivision (6) of this section.
649 The rate limitation specified in this section shall otherwise be fully
650 applicable for the current and future rating periods. The modification
651 of premium rates allowed by this subdivision shall cease to be
652 permitted for all plans and arrangements on the first rating period
653 commencing on or after July 1, 1995.

654 (2) Except in the case of a late enrollee who has failed to provide
655 evidence of insurability satisfactory to the insurer, the plan or

656 arrangement may not exclude any eligible employee or dependent
657 who would otherwise be covered under such plan or arrangement on
658 the basis of an actual or expected health condition of such person. No
659 plan or arrangement may exclude an eligible employee or eligible
660 dependent who, on the day prior to the initial effective date of the plan
661 or arrangement, was covered under the small employer's prior health
662 insurance plan or arrangement pursuant to workers' compensation,
663 continuation of benefits pursuant to federal extension requirements
664 established by the Consolidated Omnibus Budget Reconciliation Act of
665 1985 (P.L. 99-2721, as amended) or other applicable laws. The
666 employee or dependent must request coverage under the new plan or
667 arrangement on a timely basis and such coverage shall terminate in
668 accordance with the provisions of the applicable law.

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

674 (B) For rating periods commencing on or after July 1, 1994, and prior
675 to July 1, 1995, the premium rates charged or offered for a rating
676 period for all plans or arrangements may not exceed one hundred
677 twenty per cent of the base premium rate for such rating period. The
678 provisions of this subdivision shall not apply to any small employer
679 who employs more than twenty-five eligible employees.

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

684 (A) The percentage change in the base premium rate measured from
685 the first day of the prior rating period to the first day of the new rating
686 period;

687 (B) An adjustment of the small employer's premium rates for the

688 prior rating period, and adjusted pro rata for rating periods of less
689 than one year, due to the claim experience, health status or duration of
690 coverage of the employees or dependents of the small employer, such
691 adjustment (i) not to exceed ten per cent annually for the rating
692 periods commencing on or after October 1, 1993, and prior to July 1,
693 1994, and (ii) not to exceed five per cent annually for the rating periods
694 commencing on or after July 1, 1994, and prior to July 1, 1995; and

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

698 (5) (A) With respect to plans or arrangements issued on or after July
699 1, [1995] 2008, the premium rates charged or offered to small
700 employers shall be established on the basis of a community rate,
701 adjusted to reflect one or more of the following classifications:

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

704 (ii) Gender;

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

707 (iv) Industry, provided the rate factor associated with any industry
708 classification shall not vary from the arithmetic average of the highest
709 and lowest rate factors associated with all industry classifications by
710 greater than fifteen per cent of such average, and provided further, the
711 rate factors associated with any industry shall not be increased by
712 more than five per cent per year;

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

716 (vi) Administrative cost savings resulting from the administration of
717 an association group plan or a plan written pursuant to section 5-259,

718 provided the savings reflect a reduction to the small employer carrier's
719 overall retention that is measurable and specifically realized on items
720 such as marketing, billing or claims paying functions taken on directly
721 by the plan administrator or association, except that such savings may
722 not reflect a reduction realized on commissions;

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

728 (viii) Family composition, provided the small employer carrier shall
729 utilize only one or more of the following billing classifications: (I)
730 Employee; (II) employee plus family; (III) employee and spouse; (IV)
731 employee and child; (V) employee plus one dependent; and (VI)
732 employee plus two or more dependents; and

733 (ix) Status as smoker or nonsmoker.

734 (B) The small employer carrier shall quote premium rates to small
735 employers after receipt of all demographic rating classifications of the
736 small employer group. No small employer carrier may inquire
737 regarding health status or claims experience of the small employer or
738 its employees or dependents prior to the quoting of a premium rate.

739 (C) The provisions of subparagraphs (A) and (B) of this subdivision
740 shall apply to plans or arrangements issued on or after July 1, 1995.
741 The provisions of subparagraphs (A) and (B) of this subdivision shall
742 apply to plans or arrangements issued prior to July 1, 1995, as of the
743 date of the first rating period commencing on or after that date, but no
744 later than July 1, 1996.

745 (6) For any small employer plan or arrangement on which the
746 premium rates for employee and dependent coverage or both, vary
747 among employees, such variations shall be based solely on age and
748 other demographic factors permitted under subparagraph (A) of

749 subdivision (5) of this section and such variations may not be based on
750 health status, claim experience, or duration of coverage of specific
751 enrollees. Except as otherwise provided in subdivision (1) of this
752 section, any adjustment in premium rates charged for a small
753 employer plan or arrangement to reflect changes in case characteristics
754 prior to the end of a rating period shall not include any adjustment to
755 reflect the health status, medical history or medical underwriting
756 classification of any new enrollee for whom coverage begins during
757 the rating period.

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

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

769 (9) For rating periods commencing prior to July 1, 1995, in any case
770 where an insurer issues or offers a policy or contract under which
771 premium rates for a specific small employer are established or
772 adjusted in part based upon the actual or expected variation in claim
773 costs or actual or expected variation in health conditions of the
774 employees or dependents of such small employer, the insurer shall
775 make reasonable disclosure of such rating practices in solicitation and
776 sales materials utilized with respect to such policy or contract.

777 (10) If a small employer carrier denies coverage to a small employer,
778 the small employer carrier shall promptly offer the small employer the
779 opportunity to purchase a special health care plan or a small employer
780 health care plan, as appropriate. If a small employer carrier or any
781 producer representing that carrier fails, for any reason, to offer such

782 coverage as requested by a small employer, that small employer carrier
783 shall promptly offer the small employer an opportunity to purchase a
784 special health care plan or a small employer health care plan, as
785 appropriate.

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

788 (A) Encouraging or directing small employers to refrain from filing
789 an application for coverage with the small employer carrier because of
790 the health status, claims experience, industry, occupation or
791 geographic location of the small employer, except the provisions of
792 this subparagraph shall not apply to information provided by a small
793 employer carrier or producer to a small employer regarding the
794 carrier's established geographic service area or a restricted network
795 provision of a small employer carrier; or

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

799 (12) No small employer carrier shall, directly or indirectly, enter into
800 any contract, agreement or arrangement with a producer that provides
801 for or results in the compensation paid to a producer for the sale of a
802 health benefit plan to be varied because of the health status, claims
803 experience, industry, occupation or geographic area of the small
804 employer. A small employer carrier shall provide reasonable
805 compensation, as provided under the plan of operation of the
806 program, to a producer, if any, for the sale of a special or a small
807 employer health care plan. No small employer carrier shall terminate,
808 fail to renew or limit its contract or agreement of representation with a
809 producer for any reason related to the health status, claims experience,
810 occupation, or geographic location of the small employers placed by
811 the producer with the small employer carrier.

812 (13) No small employer carrier or producer shall induce or
813 otherwise encourage a small employer to separate or otherwise

814 exclude an employee from health coverage or benefits provided in
815 connection with the employee's employment.

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

819 (15) No small employer carrier or producer shall disclose (A) to a
820 small employer the fact that any or all of the eligible employees of such
821 small employer have been or will be reinsured with the pool, or (B) to
822 any eligible employee or dependent the fact that he has been or will be
823 reinsured with the pool.

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

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

833 (18) Each small employer carrier shall maintain at its principle place
834 of business a complete and detailed description of its rating practices
835 and renewal underwriting practices, including information and
836 documentation that demonstrates that its rating methods and practices
837 are based upon commonly accepted actuarial assumptions and are in
838 accordance with sound actuarial principles. Each small employer
839 carrier shall file with the commissioner annually, on or before March
840 fifteenth, an actuarial certification certifying that the carrier is in
841 compliance with this part and that the rating methods have been
842 derived using recognized actuarial principles consistent with the
843 provisions of sections 38a-564 to 38a-573, inclusive. Such certification
844 shall be in a form and manner and shall contain such information, as
845 determined by the commissioner. A copy of the certification shall be

846 retained by the small employer carrier at its principle place of business.
847 Any information and documentation described in this subdivision but
848 not subject to the filing requirement shall be made available to the
849 commissioner upon his request. Except in cases of violations of
850 sections 38a-564 to 38a-573, inclusive, the information shall be
851 considered proprietary and trade secret information and shall not be
852 subject to disclosure by the commissioner to persons outside of the
853 department except as agreed to by the small employer carrier or as
854 ordered by a court of competent jurisdiction.

855 (19) The commissioner may suspend all or any part of this section
856 relating to the premium rates applicable to one or more small
857 employers for one or more rating periods upon a filing by the small
858 employer carrier and a finding by the commissioner that either the
859 suspension is reasonable in light of the financial condition of the
860 carrier or that the suspension would enhance the efficiency and
861 fairness of the marketplace for small employer health insurance.

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

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

870 (22) With respect to plans or arrangements issued pursuant to
871 subsection (i) of section 5-259, or by an association group plan, at the
872 option of the Comptroller or the administrator of the association group
873 plan, the premium rates charged or offered to small employers
874 purchasing health insurance shall not be subject to this section,
875 provided (A) the plan or plans offered or issued cover such small
876 employers as a single entity and cover not less than ten thousand
877 eligible individuals on the date issued, (B) each small employer is
878 charged or offered the same premium rate with respect to each eligible

879 individual and dependent, and (C) the plan or plans are written on a
880 guaranteed issue basis.

881 Sec. 19. (NEW) (*Effective July 1, 2007*) There is established, within
882 existing appropriations, a Quit for Good program, which shall be a
883 smoking cessation program administered by the Department of Public
884 Health. The department shall contract with one or more entities to
885 implement the program, which shall (1) promote smoking cessation
886 among unserved or underserved populations, (2) educate the public
887 regarding the health complications relating to smoking, (3) educate the
888 public regarding methods to quit smoking, (4) provide counseling and
889 referral services for treatment, and (5) establish a system to track and
890 monitor all individuals receiving smoking cessation assistance in the
891 program. For purposes of this section, "unserved or underserved
892 populations" means individuals who are at or below two hundred per
893 cent of the federal poverty level and without health insurance that
894 comprehensively covers smoking cessation.

895 Sec. 20. Section 38a-497 of the general statutes is repealed and the
896 following is substituted in lieu thereof (*Effective July 1, 2007*):

897 Every individual health insurance policy providing coverage of the
898 type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of
899 section 38a-469 delivered, issued for delivery, amended or renewed in
900 this state on or after [October 1, 1982] July 1, 2007, shall provide that
901 coverage of a child shall terminate no earlier than the policy
902 anniversary date on or after whichever of the following occurs first, the
903 date on which the child marries [, ceases to be a dependent of the
904 policyholder, attains the age of nineteen if the child is not a full-time
905 student at an accredited institution,] or attains the age of [twenty-three
906 if the child is a full-time student at an accredited institution] twenty-
907 six.

908 Sec. 21. (NEW) (*Effective July 1, 2007*) (a) No insurer, health care
909 center, hospital and medical service corporation or other entity
910 delivering, issuing for delivery, renewing, continuing or amending any
911 individual health insurance policy in this state on or after October 1,

912 2007, shall deliver or issue for delivery in this state any policy
913 providing limited benefit coverage unless the applicant for such
914 coverage signs a statement on the application form that confirms that
915 such applicant is covered under another health benefits plan contract
916 or policy.

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

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

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

938 Sec. 22. (NEW) (*Effective July 1, 2007*) (a) No insurer, health care
939 center, hospital and medical service corporation or other entity
940 delivering, issuing for delivery, renewing, continuing or amending any
941 group health insurance policy in this state on or after October 1, 2007,
942 shall deliver or issue for delivery in this state any policy providing
943 limited benefit coverage unless each employee electing such coverage
944 confirms, in writing, that such employee is covered under another

945 health benefits plan contract or policy. Each employer that offers a
946 group health insurance policy that provides limited benefit coverage to
947 its employees shall (1) have each employee electing such coverage sign
948 a statement that confirms that such employee is covered under another
949 health benefits plan contract or policy, and (2) submit such statement
950 to such insurer, health care center, hospital and medical service
951 corporation or other entity.

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

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

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

973 Sec. 23. (NEW) (*Effective July 1, 2007*) (a) There is established a
974 permanent Commission on Healthy Lifestyles, which shall be an
975 independent body within the Office of Health Care Access for
976 administrative purposes only. Said commission shall: (1) By October 1,
977 2007, develop a marketing campaign to educate the public regarding

978 consequences of poor health and basic measures individuals should
979 take to ensure good health; and (2) make recommendations to the
980 General Assembly concerning incentives to encourage personal
981 responsibility in making healthy lifestyle choices.

982 (b) The commission shall consist of the Commissioners of Public
983 Health, Education, Social Services and Health Care Access, the
984 Insurance Commissioner, or their designees, and nine additional
985 members as follows: One member to be appointed by the Governor,
986 two to be appointed by the president pro tempore of the Senate, two to
987 be appointed by the speaker of the House of Representatives, one to be
988 appointed by the majority leader of the Senate, one to be appointed by
989 the majority leader of the House of Representatives, one to be
990 appointed by the minority leader of the Senate, and one to be
991 appointed by the minority leader of the House of Representatives.

992 (c) Notwithstanding the provisions of subsection (c) of section 4-9a
993 of the general statutes, the members of the commission shall serve for
994 staggered terms. The initial members selected shall serve as follows: (1)
995 The members appointed by the Governor and the president pro
996 tempore of the Senate shall serve for three years; (2) the members
997 appointed by the speaker of the House of Representatives and the
998 majority leader of the Senate shall serve for two years; and (3) the
999 members appointed by the majority leader and the minority leader of
1000 the House of Representatives and the minority leader of the Senate
1001 shall serve for one year. Following the expiration of such initial terms,
1002 each subsequent appointee shall serve for a term of three years. Any
1003 vacancy shall be filled by the appointing authority for the unexpired
1004 portion of the term of the member replaced. The members shall serve
1005 without compensation for their services but shall be reimbursed for
1006 their duties.

1007 (d) The commission shall meet at least quarterly each year. The
1008 commission, within available appropriations, may hire consultants to
1009 provide assistance with its responsibilities.

1010 (e) The Office of Health Care Access shall, within available

1011 appropriations, contract with one or more entities to implement the
1012 marketing campaign recommended by the Commission on Healthy
1013 Lifestyles.

1014 Sec. 24. (NEW) (*Effective July 1, 2007*) Not later than July 1, 2009, the
1015 Health Care Reform Commission, established under section 2 of this
1016 act, shall establish a nonprofit organization to be known as the
1017 Connecticut Health Quality Partnership. The Connecticut Health
1018 Quality Partnership shall: (1) Be responsible for collecting and
1019 reporting insurance claims data and other data concerning the quality
1020 of care and services provided by health plans, hospitals and health
1021 care providers for the purpose of supporting quality improvement
1022 initiatives and enabling consumers to make informed choices with
1023 respect to such providers, (2) be composed of representatives from
1024 both the private and public sectors, including, but not limited to,
1025 health insurers, hospital associations, medical societies, the
1026 Commissioners of Public Health and Social Services and consumer
1027 advocates who are not otherwise affiliated with any other members,
1028 and (3) seek funding from private and federal funding sources.

1029 Sec. 25. Subsection (d) of section 17b-192 of the general statutes is
1030 repealed and the following is substituted in lieu thereof (*Effective July*
1031 *1, 2007*):

1032 (d) The Commissioner of Social Services shall contract with
1033 federally qualified health centers or other primary care providers as
1034 necessary to provide medical services to eligible state-administered
1035 general assistance recipients pursuant to this section. The
1036 commissioner shall [, within available appropriations,] make payments
1037 to such centers based on their pro rata share of the cost of services
1038 provided or the number of clients served, or both. The Commissioner
1039 of Social Services shall [, within available appropriations,] make
1040 payments to other providers based on a methodology determined by
1041 the commissioner. The Commissioner of Social Services may reimburse
1042 for extraordinary medical services, provided such services are
1043 documented to the satisfaction of the commissioner. For purposes of

1044 this section, the commissioner may contract with a managed care
1045 organization or other entity to perform administrative functions,
1046 including a grievance process for recipients to access review of a denial
1047 of coverage for a specific medical service, and to operate the program
1048 in whole or in part. Provisions of a contract for medical services
1049 entered into by the commissioner pursuant to this section shall
1050 supersede any inconsistent provision in the regulations of Connecticut
1051 state agencies. A recipient who has exhausted the grievance process
1052 established through such contract and wishes to seek further review of
1053 the denial of coverage for a specific medical service may request a
1054 hearing in accordance with the provisions of section 17b-60. On July 1,
1055 2007, the amount paid pursuant to this section to each federally
1056 qualified health center or other primary care provider shall be
1057 increased by not less than five per cent. On July 1, 2008, and annually
1058 thereafter, such payments shall increase by not less than the
1059 percentage increase in the consumer price index.

1060 Sec. 26. (NEW) (*Effective July 1, 2007*) (a) On October 1, 2007, and
1061 every five years thereafter, the Office of Health Care Access shall
1062 determine the number of Connecticut residents who are not covered
1063 by a health insurance plan. If the number of uninsured residents has
1064 not decreased by fifty per cent by October 1, 2012, the Health Care
1065 Reform Commission shall determine whether it is advisable to require
1066 residents to have health insurance. Not later than January 1, 2013, the
1067 commission shall report its findings to the joint standing committee of
1068 the General Assembly having cognizance of matters relating to
1069 insurance.

1070 (b) Not later than December 31, 2007, and annually thereafter, the
1071 Office of Health Care Access shall conduct a survey to determine the
1072 number of Connecticut employers that are providing health care
1073 benefits to employees who reside in this state. Not later than January 1,
1074 2008, and annually thereafter, said office shall submit a report of its
1075 findings to the joint standing committee of the General Assembly
1076 having cognizance of matters relating to insurance.

1077 Sec. 27. (*Effective July 1, 2007*) Notwithstanding the provisions of
1078 section 4-28e of the general statutes, the sum remaining in the Tobacco
1079 and Health Trust Fund shall be transferred from said fund to the
1080 General Fund, of which twenty million dollars shall be used by the
1081 Department of Public Health for the Smoke-Free Connecticut Program.

1082 Sec. 28. (*Effective July 1, 2007*) The sum of one million six hundred
1083 thousand dollars is appropriated to the Department of Public Health,
1084 from the General Fund, for the fiscal year ending June 30, 2008, for the
1085 purpose of providing grants in the amount of two hundred thousand
1086 dollars to eight different groups representing the interests of
1087 Connecticut employers. Such grants shall be used to train employers to
1088 effectively educate employees concerning the financial and health
1089 benefits of making lifestyle choices that promote good health,
1090 including maintaining a healthy weight and regularly exercising.

1091 Sec. 29. (*Effective July 1, 2007*) An amount is appropriated to the
1092 Department of Social Services, from the General Fund, for the fiscal
1093 year ending June 30, 2008, for the purposes of section 13 of this act.

1094 Sec. 30. (*Effective July 1, 2007*) The sum of five hundred thousand
1095 dollars is appropriated to the Department of Social Services, from the
1096 General Fund, for the fiscal year ending June 30, 2008, for the purpose
1097 of providing grants to community-based organizations under
1098 subsection (e) of section 17b-297 of the general statutes, as amended by
1099 this act.

1100 Sec. 31. (*Effective July 1, 2007*) The sum of one million dollars is
1101 appropriated to the Insurance Department, from the General Fund, for
1102 the fiscal year ending June 30, 2008, for the purpose of providing start-
1103 up costs for the Connecticut Connector.

1104 Sec. 32. Section 17b-261c of the general statutes is repealed. (*Effective*
1105 *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>	17b-267
Sec. 13	<i>July 1, 2007</i>	New section
Sec. 14	<i>July 1, 2007</i>	17b-297
Sec. 15	<i>July 1, 2007</i>	17b-261(a)
Sec. 16	<i>July 1, 2007</i>	17b-261
Sec. 17	<i>July 1, 2007</i>	17b-292
Sec. 18	<i>July 1, 2007</i>	38a-567
Sec. 19	<i>July 1, 2007</i>	New section
Sec. 20	<i>July 1, 2007</i>	38a-497
Sec. 21	<i>July 1, 2007</i>	New section
Sec. 22	<i>July 1, 2007</i>	New section
Sec. 23	<i>July 1, 2007</i>	New section
Sec. 24	<i>July 1, 2007</i>	New section
Sec. 25	<i>July 1, 2007</i>	17b-192(d)
Sec. 26	<i>July 1, 2007</i>	New section
Sec. 27	<i>July 1, 2007</i>	New section
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>	Repealer section

FIN *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 \$
Social Services, Dept.	GF - Cost	Significant	Significant
Insurance Dept.	GF - Cost	1,000,000	See Below
Health Care Access, Off.	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 places 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 41 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.

Section 6 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 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 7 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 8 requires the Department of Social Services (DSS) to seek a federal waiver to receive reimbursement for costs incurred under

sections 6 and 7 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 6 and 7. 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 9 specifies that no employer may offer health benefits of a lesser value to lower-paid employees than higher-paid employee.

Section 10 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 11 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 12 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 13 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 14 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 15 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 13 of the bill. These costs would be reimbursed 50% by the federal government under the Medicaid program.

Section 16 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 17 re-establishes the continuous eligibility policy for children in the HUSKY plan. Assuming the rate increases included in section 13, 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 17 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 18 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 19 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 27. 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 27, 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.¹

¹ The fringe benefit costs for state employees are budgeted centrally in the Miscellaneous Accounts administered by the Comptroller. The estimated first year fringe benefit rate 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%.

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 20, 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 21 and 22 concern requirements of insurers who offer limited benefit coverage. These changes are not anticipated to have a direct fiscal impact on the state.

Section 23 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 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.²

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 24 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 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.

² 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.

Section 25 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 26 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 26 the requirement that associated costs be accommodated within available appropriations will likely result in one of four outcomes detailed in section 2 above.

Section 27 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 28 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 29 makes an unspecified appropriation to DSS. As no funds are actually appropriated, these sections have no fiscal impact.

Sections 30 and 31 make appropriations as noted in the above narrative.

Section 32 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, HUSKY program changes, and public health initiatives. It establishes a Health Care Reform Commission, the Connecticut Connector, a Healthy Lifestyles Commission, a health savings account incentive program, and a premium subsidy program. It also makes several appropriations.

EFFECTIVE DATE: July 1, 2007

§§ 2 & 24 – HEALTH CARE REFORM COMMISSION

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, the commission 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.

Membership

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

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.

§§ 3-5 & 31 – CONNECTICUT CONNECTOR

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

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 material that, compares 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. 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
12. 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

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

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 for which 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

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.

Appropriation

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

§ 6 – HEALTH SAVINGS ACCOUNT INCENTIVE PROGRAM

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.

<i>Family Income = 200% or Less</i>	
<i>Family HSA Contribution</i>	<i>Connector Contribution</i>
\$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.

§ 7 – PREMIUM SUBSIDY PROGRAM

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.

§ 8 – FEDERAL WAIVER TO OFFSET COSTS

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.

§§ 9, 18, 20-22 – HEALTH INSURANCE CHANGES

Employer Plans for Low-Income Workers

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

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

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

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 that 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 under 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 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.

§§ 10-17, 29-30, & 32 – HUSKY AND MEDICAID CHANGES

Increase in Income Limit for Adult Caretaker Relatives

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

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

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

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

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

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

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

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

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.)

§ 25 – STATE-ADMINISTERED GENERAL ASSISTANCE (SAGA)

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.

§§ 19, 23, & 26-28 – PUBLIC HEALTH PROGRAMS

Smoking Cessation Program

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

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.

Connecticut's Uninsured

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

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 (which is presumably the "Quit for Good" program discussed above).

DPH Appropriation

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

On April 11, the House referred the bill (File 219) to the Public Health Committee, which reported it favorably.

On April 25, the House referred the bill to the Appropriations Committee, which reported a substitute bill deleting the requirement that providers accept and provide services to anyone enrolled in HUSKY and Medicaid.

On May 22, the House referred the bill (File 831) to the Finance, Revenue and Bonding Committee, which reported this substitute, deleting:

1. refundable tax credits for small employers offering employees health insurance,
2. a reduction in HMO premium taxes,
3. a repeal of the sales tax on health clubs,
4. a tax on cosmetic medical procedures,
5. an increase in the cigarette tax, and
6. a limit on how much physicians and hospitals can charge uninsured people.

Related Bills

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

<i>Bill No.</i>	<i>Committee</i>	<i>File No.</i>
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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, 856
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 Passed in concurrence PA # TBD	Insurance	243, 858	Limited benefit health plans
HB 6055 Passed in concurrence, PA 07-75	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)

Finance, Revenue and Bonding Committee

Joint Favorable Substitute

Yea 37 Nay 14 (05/23/2007)