



Senate

General Assembly

File No. 472

January Session, 2007

Substitute Senate Bill No. 1

Senate, April 12, 2007

The Committee on Public Health reported through SEN. HANDLEY of the 4th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING THE HEALTHFIRST CONNECTICUT INITIATIVE.

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

1 Section 1. Section 17b-28e of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective July 1, 2007*):

3 (a) Not later than September 30, 2002, the Commissioner of Social
4 Services shall submit an amendment to the Medicaid state plan to
5 implement the provisions of public act 02-1 of the May 9 special
6 session* concerning optional services under the Medicaid program.
7 Said state plan amendment shall supersede any regulations of
8 Connecticut state agencies concerning such optional services.

9 (b) The Commissioner of Social Services shall amend the Medicaid
10 state plan to include foreign language interpreter services provided to
11 any beneficiary with limited English proficiency as a covered service
12 under the Medicaid program.

13 Sec. 2. Section 17b-261 of the general statutes is repealed and the
14 following is substituted in lieu thereof (*Effective July 1, 2007*):

15 (a) Medical assistance shall be provided for any otherwise eligible
16 person whose income, including any available support from legally
17 liable relatives and the income of the person's spouse or dependent
18 child, is not more than one hundred forty-three per cent, pending
19 approval of a federal waiver applied for pursuant to subsection (d) of
20 this section, of the benefit amount paid to a person with no income
21 under the temporary family assistance program in the appropriate
22 region of residence and if such person is an institutionalized
23 individual as defined in Section 1917(c) of the Social Security Act, 42
24 USC 1396p(c), and has not made an assignment or transfer or other
25 disposition of property for less than fair market value for the purpose
26 of establishing eligibility for benefits or assistance under this section.
27 Any such disposition shall be treated in accordance with Section
28 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
29 property made on behalf of an applicant or recipient or the spouse of
30 an applicant or recipient by a guardian, conservator, person
31 authorized to make such disposition pursuant to a power of attorney
32 or other person so authorized by law shall be attributed to such
33 applicant, recipient or spouse. A disposition of property ordered by a
34 court shall be evaluated in accordance with the standards applied to
35 any other such disposition for the purpose of determining eligibility.
36 The commissioner shall establish the standards for eligibility for
37 medical assistance at one hundred forty-three per cent of the benefit
38 amount paid to a family unit of equal size with no income under the
39 temporary family assistance program in the appropriate region of
40 residence, [pending federal approval, except that the] Except as
41 provided in section 17b-277, as amended by this act, the medical
42 assistance program shall provide coverage to persons under the age of
43 nineteen [up to one hundred eighty-five per cent of the federal poverty
44 level without an asset limit. Said medical assistance program shall also
45 provide coverage to persons under the age of nineteen] and their
46 parents and needy caretaker relatives, who qualify for coverage under
47 Section 1931 of the Social Security Act, with family income up to one

48 hundred [fifty] eighty-five per cent of the federal poverty level without
49 an asset limit. [, upon the request of such a person or upon a
50 redetermination of eligibility.] Such levels shall be based on the
51 regional differences in such benefit amount, if applicable, unless such
52 levels based on regional differences are not in conformance with
53 federal law. Any income in excess of the applicable amounts shall be
54 applied as may be required by said federal law, and assistance shall be
55 granted for the balance of the cost of authorized medical assistance. All
56 contracts entered into on and after July 1, 1997, pursuant to this section
57 shall include provisions for collaboration of managed care
58 organizations with the Nurturing Families Network established
59 pursuant to section 17a-56. The Commissioner of Social Services shall
60 provide applicants for assistance under this section, at the time of
61 application, with a written statement advising them of (1) the effect of
62 an assignment or transfer or other disposition of property on eligibility
63 for benefits or assistance, (2) the effect that having income that exceeds
64 the limits prescribed in this subsection will have with respect to
65 program eligibility, (3) the availability of HUSKY Plan, Part B health
66 insurance benefits for persons who are not eligible for assistance
67 pursuant to this subsection or who are subsequently determined
68 ineligible for assistance pursuant to this subsection, and [(2)] (4) the
69 availability of, and eligibility for, services provided by the Nurturing
70 Families Network established pursuant to section 17a-56.

71 (b) For the purposes of the Medicaid program, the Commissioner of
72 Social Services shall consider parental income and resources as
73 available to a child under eighteen years of age who is living with his
74 or her parents and is blind or disabled for purposes of the Medicaid
75 program, or to any other child under twenty-one years of age who is
76 living with his or her parents.

77 (c) For the purposes of determining eligibility for the Medicaid
78 program, an available asset is one that is actually available to the
79 applicant or one that the applicant has the legal right, authority or
80 power to obtain or to have applied for the applicant's general or
81 medical support. If the terms of a trust provide for the support of an

82 applicant, the refusal of a trustee to make a distribution from the trust
83 does not render the trust an unavailable asset. Notwithstanding the
84 provisions of this subsection, the availability of funds in a trust or
85 similar instrument funded in whole or in part by the applicant or the
86 applicant's spouse shall be determined pursuant to the Omnibus
87 Budget Reconciliation Act of 1993, 42 USC 1396p. The provisions of
88 this subsection shall not apply to special needs trust, as defined in 42
89 USC 1396p(d)(4)(A).

90 (d) The transfer of an asset in exchange for other valuable
91 consideration shall be allowable to the extent the value of the other
92 valuable consideration is equal to or greater than the value of the asset
93 transferred.

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

98 (f) To the extent permitted by federal law, Medicaid eligibility shall
99 be extended for one year to a family that becomes ineligible for
100 medical assistance under Section 1931 of the Social Security Act due to
101 income from employment by one of its members who is a caretaker
102 relative or due to receipt of child support income. A family receiving
103 extended benefits on July 1, 2005, shall receive the balance of such
104 extended benefits, provided no such family shall receive more than
105 twelve additional months of such benefits.

106 (g) An institutionalized spouse applying for Medicaid and having a
107 spouse living in the community shall be required, to the maximum
108 extent permitted by law, to divert income to such community spouse
109 in order to raise the community spouse's income to the level of the
110 minimum monthly needs allowance, as described in Section 1924 of
111 the Social Security Act. Such diversion of income shall occur before the
112 community spouse is allowed to retain assets in excess of the
113 community spouse protected amount described in Section 1924 of the
114 Social Security Act. The Commissioner of Social Services, pursuant to

115 section 17b-10, may implement the provisions of this subsection while
116 in the process of adopting regulations, provided the commissioner
117 prints notice of intent to adopt the regulations in the Connecticut Law
118 Journal within twenty days of adopting such policy. Such policy shall
119 be valid until the time final regulations are effective.

120 [(h) The Commissioner of Social Services shall, to the extent
121 permitted by federal law, or, pursuant to an approved waiver of
122 federal law submitted by the commissioner, in accordance with the
123 provisions of section 17b-8, impose the following cost-sharing
124 requirements under the HUSKY Plan, on all parent and needy
125 caretaker relatives with incomes exceeding one hundred per cent of the
126 federal poverty level: (1) A twenty-five-dollar premium per month per
127 parent or needy caretaker relative; and (2) a copayment of one dollar
128 per visit for outpatient medical services delivered by an enrolled
129 Medicaid or HUSKY Plan provider. The commissioner may implement
130 policies and procedures necessary to administer the provisions of this
131 subsection while in the process of adopting such policies and
132 procedures as regulations, provided the commissioner publishes notice
133 of the intent to adopt regulations in the Connecticut Law Journal not
134 later than twenty days after implementation. Policies and procedures
135 implemented pursuant to this subsection shall be valid until the time
136 final regulations are adopted.]

137 [(i)] (h) Medical assistance shall be provided, in accordance with the
138 provisions of subsection (e) of section 17a-6, to any child under the
139 supervision of the Commissioner of Children and Families who is not
140 receiving Medicaid benefits, has not yet qualified for Medicaid benefits
141 or is otherwise ineligible for such benefits because of institutional
142 status. To the extent practicable, the Commissioner of Children and
143 Families shall apply for, or assist such child in qualifying for, the
144 Medicaid program.

145 [(j)] (i) The Commissioner of Social Services shall provide Early and
146 Periodic Screening, Diagnostic and Treatment program services, as
147 required and defined as of December 31, 2005, by 42 USC 1396a(a)(43),

148 42 USC 1396d(r) and 42 USC 1396d(a)(4)(B) and applicable federal
149 regulations, to all persons who are under the age of twenty-one and
150 otherwise eligible for medical assistance under this section.

151 (j) Notwithstanding the provisions of this section, the Commissioner
152 of Social Services, pursuant to 42 USC 1396a(r)(2), shall file an
153 amendment to the Medicaid state plan that allows the commissioner,
154 when making Medicaid income eligibility determinations, to establish
155 and maintain the level of eligibility for persons who are aged, blind or
156 disabled at the same income level used to determine eligibility for
157 parents and needy caretaker relatives under the HUSKY Plan, Part A,
158 by establishing a special income disregard that is applicable only to
159 aged, blind or disabled individuals and only under the Medicaid
160 program.

161 Sec. 3. Section 17b-297 of the general statutes is repealed and the
162 following is substituted in lieu thereof (*Effective July 1, 2007*):

163 (a) The [commissioner] Commissioner of Social Services, in
164 consultation with the Children's Health Council, the Medicaid
165 Managed Care Council and the 2-1-1 Infoline [of Connecticut]
166 program, shall develop mechanisms [for outreach for] to increase
167 outreach and maximize enrollment of eligible children and adults in
168 the HUSKY Plan, Part A [and] or Part B. [, including, but not limited
169 to, development of mail-in applications and appropriate outreach
170 materials through the Department of Revenue Services, the Labor
171 Department, the Department of Social Services, the Department of
172 Public Health, the Department of Children and Families and the Office
173 of Protection and Advocacy for Persons with Disabilities.] Such
174 mechanisms shall include, but not be limited to, the development and
175 implementation of a mail-in and on-line application systems. In
176 addition, the Commissioner of Social Services shall develop
177 appropriate outreach materials and in collaboration with the
178 Departments of Public Health, Children and Families, Mental Health
179 and Addiction Services, Mental Retardation, Education, Revenue
180 Services and Motor Vehicles, the Labor Department and the Office of

181 Protection and Advocacy for Persons with Disabilities and, as
182 appropriate, disseminate such outreach materials. All outreach
183 materials shall be approved by the commissioner pursuant to Subtitle J
184 of Public Law 105-33.

185 [(b) The commissioner shall include in such outreach efforts
186 information on the Medicaid program for the purpose of maximizing
187 enrollment of eligible children and the use of federal funds.]

188 [(c)] (b) The commissioner shall, within available appropriations,
189 contract with severe need schools and community-based organizations
190 for purposes of public education, outreach and recruitment of eligible
191 children and adults, including the distribution of applications and
192 information regarding enrollment in the HUSKY Plan, Part A and Part
193 B. In awarding such contracts, the commissioner shall consider the
194 marketing, outreach and recruitment efforts of organizations. For the
195 purposes of this subsection, (1) "community-based organizations" shall
196 include, but not be limited to, day care centers, schools, school-based
197 health clinics, community-based diagnostic and treatment centers and
198 hospitals, and (2) "severe need school" means a school in which forty
199 per cent or more of the lunches served are served to students who are
200 eligible for free or reduced price lunches.

201 [(d) All outreach materials shall be approved by the commissioner
202 pursuant to Subtitle J of Public Law 105-33.]

203 [(e)] (c) Not later than January 1, [1999] 2008, and annually
204 thereafter, the commissioner shall [submit a] report, in accordance
205 with section 11-4a, to the Governor and the joint standing committees
206 of the General Assembly having cognizance of matters relating to
207 human services, public health and appropriations and the budgets of
208 state agencies on the implementation of and the results of the
209 [community-based outreach program] outreach efforts specified in
210 subsections (a) [to (c), inclusive,] and (b) of this section.

211 Sec. 4. Section 17b-297b of the general statutes is repealed and the
212 following is substituted in lieu thereof (*Effective July 1, 2007*):

213 (a) Each local or regional board of education or similar body
214 governing a nonpublic school or schools shall, at the beginning of each
215 school year, provide to the parent or guardian of any pupil attending
216 such school outreach materials concerning eligibility for health
217 insurance coverage under the HUSKY Plan, Part A and Part B. The
218 Department of Social Services shall develop such outreach materials in
219 accordance with the provisions of sections 17b-297, as amended by this
220 act, and shall disseminate such outreach materials to schools.

221 [(a)] (b) To the extent permitted by federal law, the Commissioners
222 of Social Services and Education shall jointly establish procedures for
223 the sharing of information contained in applications for free and
224 reduced price meals under the National School Lunch Program for the
225 purpose of determining whether children participating in said
226 program are eligible for coverage under the HUSKY Plan, Part A and
227 Part B. The Commissioner of Social Services shall take all actions
228 necessary to ensure that children identified as eligible for the HUSKY
229 Plan are able to enroll in said plan.

230 [(b)] (c) The Commissioner of Education shall establish procedures
231 whereby an individual may apply for the HUSKY Plan, Part A or Part
232 B, at the same time such individual applies for the National School
233 Lunch Program.

234 Sec. 5. (NEW) (*Effective July 1, 2007*) (a) The Department of Social
235 Services, in consultation with the Department of Public Health, shall
236 establish a joint program between public and private entities for the
237 establishment and implementation of a multiyear, state-wide public
238 information campaign for the purpose of promoting enrollment in the
239 HUSKY Plan, Parts A and B of all persons who may be eligible for such
240 health insurance benefits.

241 (b) Notwithstanding the provisions of sections 4-212 to 4-219,
242 inclusive, of the general statutes, the Department of Social Services, in
243 consultation with the Department of Public Health, shall solicit bids
244 from private organizations for the design and operation of the
245 information campaign. Such bids shall be solicited by sending notice to

246 prospective organizations and by posting notice on public bulletin
247 boards within the departments. Each bid shall be opened publicly at
248 the time stated in the notice soliciting such bid. Acceptance of a bid by
249 the departments shall be based on standard specifications adopted by
250 the departments. The Department of Social Services may accept gifts,
251 donations, bequests, grants or funds from public or private agencies
252 for any or all of the purposes of this section.

253 (c) On January 1, 2008, and annually thereafter, the Commissioner
254 of Social Services shall report, in accordance with section 11-4a of the
255 general statutes, to the joint standing committees of the General
256 Assembly having cognizance of matters relating to human services,
257 public health and appropriations and the budgets of state agencies on
258 the status of the program established pursuant to this section.

259 Sec. 6. Section 17b-289 of the general statutes is repealed and the
260 following is substituted in lieu thereof (*Effective July 1, 2007*):

261 (a) Sections 17b-289 to 17b-303, inclusive, and section 16 of public
262 act 97-1 of the October 29 special session* shall be known as the
263 "HUSKY and HUSKY Plus Act".

264 (b) Children, caretaker relatives and pregnant women receiving
265 assistance under section 17b-261 or 17b-277 shall be participants in the
266 HUSKY Plan, Part A and children receiving assistance under sections
267 17b-289 to 17b-303, inclusive, and section 16 of public act 97-1 of the
268 October 29 special session* shall be participants in the HUSKY Plan,
269 Part B. For purposes of marketing and outreach and enrollment of
270 persons eligible for assistance, both parts shall be known as the
271 HUSKY Plan.

272 Sec. 7. Section 17b-292 of the general statutes is repealed and the
273 following is substituted in lieu thereof (*Effective July 1, 2007*):

274 (a) A child who resides in a household with a family income which
275 exceeds one hundred eighty-five per cent of the federal poverty level
276 and does not exceed three hundred per cent of the federal poverty

277 level may be eligible for subsidized benefits under the HUSKY Plan,
278 Part B.

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

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

285 (d) A child who has been determined to be eligible for benefits
286 under either the HUSKY Plan, Part A or Part B shall remain eligible for
287 such plan for a period of twelve months from such child's
288 determination of eligibility unless the child attains the age of nineteen
289 or is no longer a resident of the state. An adult who has been
290 determined to be eligible for benefits under the HUSKY Plan, Part A
291 shall remain eligible for such plan for a period of twelve months from
292 such adult's determination of eligibility unless the adult is no longer a
293 resident of the state. During the twelve-month period following the
294 date that an adult or child is determined eligible for the HUSKY Plan,
295 Part A or Part B, the adult or family of such child shall comply with
296 federal requirements concerning the reporting of information to the
297 department, including, but not limited to, change of address
298 information.

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

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

307 [(f)] (g) The commissioner shall implement presumptive eligibility

308 for children applying for Medicaid. Such presumptive eligibility
309 determinations shall be in accordance with applicable federal law and
310 regulations. The commissioner shall adopt regulations, in accordance
311 with chapter 54, to establish standards and procedures for the
312 designation of organizations as qualified entities to grant presumptive
313 eligibility. Qualified entities shall ensure that, at the time a
314 presumptive eligibility determination is made, a completed application
315 for Medicaid is submitted to the department for a full eligibility
316 determination. In establishing such standards and procedures, the
317 commissioner shall ensure the representation of state-wide and local
318 organizations that provide services to children of all ages in each
319 region of the state.

320 ~~[(g)]~~ (h) The commissioner shall enter into a contract with an entity
321 to be a single point of entry servicer for applicants and enrollees under
322 the HUSKY Plan, Part A and Part B. ~~[The servicer]~~ The commissioner,
323 in consultation with the servicer, shall establish a centralized unit to be
324 responsible for processing all applications for assistance under to be
325 HUSKY Plan, Part A and Part B. The department, through its contract
326 with the servicer, shall ensure that a child who is determined to be
327 eligible for benefits under the HUSKY Plan, Part A, or the HUSKY
328 Plan, Part B has uninterrupted health insurance coverage for as long as
329 the parent or guardian elects to enroll or re-enroll such child in the
330 HUSKY Plan, Part A or Part B. The commissioner, in consultation with
331 the servicer, and in accordance with the provisions of section 17b-297,
332 as amended by this act, shall jointly market both Part A and Part B
333 together as the HUSKY Plan [~~Such servicer~~] and shall develop and
334 implement public information and outreach activities with community
335 programs. Such servicer shall electronically transmit data with respect
336 to enrollment and disenrollment in the HUSKY Plan, Part A and Part B
337 to the commissioner.

338 [(h)] (i) Upon the expiration of any contractual provisions entered
339 into pursuant to subsection ~~[(g)]~~ (h) of this section, the commissioner
340 shall develop a new contract for single point of entry services and
341 managed care enrollment brokerage services. The commissioner may

342 enter into one or more contractual arrangements for such services for a
343 contract period not to exceed seven years. Such contracts shall include
344 performance measures, including, but not limited to, specified time
345 limits for the processing of applications, parameters setting forth the
346 requirements for a completed and reviewable application and the
347 percentage of applications forwarded to the department in a complete
348 and timely fashion. Such contracts shall also include a process for
349 identifying and correcting noncompliance with established
350 performance measures, including sanctions applicable for instances of
351 continued noncompliance with performance measures.

352 [(i)] (j) The single point of entry servicer shall send [an application]
353 all applications and supporting documents to the commissioner for
354 determination of eligibility. [of a child who resides in a household with
355 a family income of one hundred eighty-five per cent or less of the
356 federal poverty level.] The servicer shall enroll eligible beneficiaries in
357 the applicant's choice of managed care plan. Upon enrollment in a
358 managed care plan, an eligible HUSKY Plan Part A or Part B
359 beneficiary shall remain enrolled in such managed care plan for twelve
360 months from the date of such enrollment unless (1) an eligible
361 beneficiary demonstrates good cause to the satisfaction of the
362 commissioner of the need to enroll in a different managed care plan, or
363 (2) the beneficiary no longer meets program eligibility requirements.

364 [(j)] (k) Not [more than twelve] later than ten months after the
365 determination of eligibility for benefits under the HUSKY Plan, Part A
366 and Part B and annually thereafter, the commissioner or the servicer,
367 as the case may be, shall determine if the child continues to be eligible
368 for the plan. The commissioner or the servicer shall mail or, upon
369 request of a participant, electronically transmit an application form to
370 each participant in the plan for the purposes of obtaining information
371 to make a determination on continued eligibility beyond the twelve
372 months of initial eligibility. To the extent permitted by federal law, in
373 determining eligibility for benefits under the HUSKY Plan, Part A or
374 Part B with respect to family income, the commissioner or the servicer
375 shall rely upon information provided in such form by the participant

376 unless the commissioner or the servicer has reason to believe that such
377 information is inaccurate or incomplete. The Department of Social
378 Services shall annually review a random sample of cases to confirm
379 that, based on the statistical sample, relying on such information is not
380 resulting in ineligible clients receiving benefits under HUSKY Plan
381 Part A or Part B. The determination of eligibility shall be coordinated
382 with health plan open enrollment periods.

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

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

394 Sec. 8. Section 17b-192 of the general statutes is repealed and the
395 following is substituted in lieu thereof (*Effective July 1, 2007*):

396 (a) The Commissioner of Social Services shall implement a state
397 medical assistance component of the state-administered general
398 assistance program for persons with income that does not exceed the
399 federal poverty level and who are ineligible for Medicaid. [Not later
400 than October 1, 2003, each] Earned monthly gross income of up to one
401 hundred fifty dollars shall be disregarded. Unearned income shall not
402 be disregarded. No person who has family assets exceeding one
403 thousand dollars shall be eligible. No person shall be eligible for
404 assistance under this section if such person made, during the three
405 months prior to the month of application, an assignment or transfer or
406 other disposition of property for less than fair market value. The
407 number of months of ineligibility due to such disposition shall be
408 determined by dividing the fair market value of such property, less

409 any consideration received in exchange for its disposition, by five
410 hundred dollars. Such period of ineligibility shall commence in the
411 month in which the person is otherwise eligible for benefits. Any
412 assignment, transfer or other disposition of property, on the part of the
413 transferor, shall be presumed to have been made for the purpose of
414 establishing eligibility for benefits or services unless such person
415 provides convincing evidence to establish that the transaction was
416 exclusively for some other purpose.

417 (b) Each person eligible for state-administered general assistance
418 shall be entitled to receive medical care through a federally qualified
419 health center or other primary care provider as determined by the
420 commissioner. The Commissioner of Social Services shall determine
421 appropriate service areas and shall, in the commissioner's discretion,
422 contract with community health centers, other similar clinics, and
423 other primary care providers, if necessary, to assure access to primary
424 care services for recipients who live farther than a reasonable distance
425 from a federally qualified health center. The commissioner shall assign
426 and enroll eligible persons in federally qualified health centers and
427 with any other providers contracted for the program because of access
428 needs. [Not later than October 1, 2003, each] Each person eligible for
429 state-administered general assistance shall be entitled to receive
430 hospital services. Medical services under the program shall be limited
431 to the services provided by a federally qualified health center, hospital,
432 or other provider contracted for the program at the commissioner's
433 discretion because of access needs. The commissioner shall ensure that
434 ancillary services and specialty services are provided by a federally
435 qualified health center, hospital, or other providers contracted for the
436 program at the commissioner's discretion. Ancillary services include,
437 but are not limited to, radiology, laboratory, and other diagnostic
438 services not available from a recipient's assigned primary-care
439 provider, and durable medical equipment. Specialty services are
440 services provided by a physician with a specialty that are not included
441 in ancillary services. In no event shall ancillary or specialty services
442 provided under the program exceed such services provided under the
443 state-administered general assistance program on July 1, 2003.

444 [Eligibility criteria concerning income shall be the same as the
445 medically needy component of the Medicaid program, except that
446 earned monthly gross income of up to one hundred fifty dollars shall
447 be disregarded. Unearned income shall not be disregarded. No person
448 who has family assets exceeding one thousand dollars shall be eligible.
449 No person eligible for Medicaid shall be eligible to receive medical
450 care through the state-administered general assistance program. No
451 person shall be eligible for assistance under this section if such person
452 made, during the three months prior to the month of application, an
453 assignment or transfer or other disposition of property for less than
454 fair market value. The number of months of ineligibility due to such
455 disposition shall be determined by dividing the fair market value of
456 such property, less any consideration received in exchange for its
457 disposition, by five hundred dollars. Such period of ineligibility shall
458 commence in the month in which the person is otherwise eligible for
459 benefits. Any assignment, transfer or other disposition of property, on
460 the part of the transferor, shall be presumed to have been made for the
461 purpose of establishing eligibility for benefits or services unless such
462 person provides convincing evidence to establish that the transaction
463 was exclusively for some other purpose.]

464 [(b) Recipients covered by a general assistance program operated by
465 a town shall be assigned and enrolled in federally qualified health
466 centers and with any other providers in the same manner as recipients
467 of medical assistance under the state-administered general assistance
468 program pursuant to subsection (a) of this section.]

469 (c) [On and after October 1, 2003, pharmacy] Pharmacy services
470 shall be provided to recipients of state-administered general assistance
471 through the federally qualified health center to which they are
472 assigned or through a pharmacy with which the health center
473 contracts. [Prior to said date, pharmacy services shall be provided as
474 provided under the Medicaid program.] Recipients who are assigned
475 to a community health center or similar clinic or primary care provider
476 other than a federally qualified health center or to a federally qualified
477 health center that does not have a contract for pharmacy services shall

478 receive pharmacy services at pharmacies designated by the
479 commissioner. The Commissioner of Social Services or the managed
480 care organization or other entity performing administrative functions
481 for the program as permitted in subsection (d) of this section, shall
482 require prior authorization for coverage of drugs for the treatment of
483 erectile dysfunction. The commissioner or the managed care
484 organization or other entity performing administrative functions for
485 the program may limit or exclude coverage for drugs for the treatment
486 of erectile dysfunction for persons who have been convicted of a sexual
487 offense who are required to register with the Commissioner of Public
488 Safety pursuant to chapter 969.

489 (d) The Commissioner of Social Services shall contract with
490 federally qualified health centers or other primary care providers as
491 necessary to provide medical services to eligible state-administered
492 general assistance recipients pursuant to this section. The
493 commissioner shall, within available appropriations, make payments
494 to such centers based on their pro rata share of the cost of services
495 provided or the number of clients served, or both. The Commissioner
496 of Social Services shall, within available appropriations, make
497 payments to other providers based on a methodology determined by
498 the commissioner. The Commissioner of Social Services may reimburse
499 for extraordinary medical services, provided such services are
500 documented to the satisfaction of the commissioner. For purposes of
501 this section, the commissioner may contract with a managed care
502 organization or other entity to perform administrative functions,
503 including a grievance process for recipients to access review of a denial
504 of coverage for a specific medical service, and to operate the program
505 in whole or in part. Provisions of a contract for medical services
506 entered into by the commissioner pursuant to this section shall
507 supersede any inconsistent provision in the regulations of Connecticut
508 state agencies. A recipient who has exhausted the grievance process
509 established through such contract and wishes to seek further review of
510 the denial of coverage for a specific medical service may request a
511 hearing in accordance with the provisions of section 17b-60.

512 (e) Each federally qualified health center participating in the
513 program shall [, within thirty days of August 20, 2003,] enroll in the
514 federal Office of Pharmacy Affairs Section 340B drug discount
515 program established pursuant to 42 USC 256b to provide pharmacy
516 services to recipients at Federal Supply Schedule costs. Each such
517 health center may establish an on-site pharmacy or contract with a
518 commercial pharmacy to provide such pharmacy services.

519 (f) The Commissioner of Social Services shall, within available
520 appropriations, make payments to hospitals for inpatient services
521 based on their pro rata share of the cost of services provided or the
522 number of clients served, or both. The Commissioner of Social Services
523 shall, within available appropriations, make payments for any
524 ancillary or specialty services provided to state-administered general
525 assistance recipients under this section based on a methodology
526 determined by the commissioner.

527 (g) On or before [~~March 1, 2004~~] January 1, 2008, the Commissioner
528 of Social Services shall seek a waiver of federal law [under the Health
529 Insurance Flexibility and Accountability demonstration initiative] for
530 the purpose of extending health insurance coverage under Medicaid to
531 persons qualifying for medical assistance under the state-administered
532 general assistance program. The provisions of section 17b-8 shall apply
533 to this section.

534 (h) The commissioner, pursuant to section 17b-10, may implement
535 policies and procedures to administer the provisions of this section
536 while in the process of adopting such policies and procedures as
537 regulation, provided the commissioner prints notice of the intent to
538 adopt the regulation in the Connecticut Law Journal not later than
539 twenty days after the date of implementation. Such policy shall be
540 valid until the time final regulations are adopted.

541 Sec. 9. Subsection (a) of section 17b-277 of the general statutes is
542 repealed and the following is substituted in lieu thereof (*Effective July*
543 *1, 2007*):

544 (a) The Commissioner of Social Services shall provide, in accordance
545 with federal law and regulations, medical assistance under the
546 Medicaid program to needy pregnant women [and children up to one
547 year of age] whose families have an income [up to one hundred eighty-
548 five] not exceeding three hundred per cent of the federal poverty level.

549 Sec. 10. (NEW) (*Effective July 1, 2007*) On or before January 1, 2008,
550 the Commissioner of Social Services, shall seek a waiver under federal
551 law under the Health Insurance Flexibility and Accountability
552 demonstration proposal to provide health insurance coverage to
553 pregnant women, who do not otherwise have creditable coverage, as
554 defined in 42 USC 300gg(c), and with incomes above one hundred
555 eighty-five per cent of the federal poverty level but not in excess of
556 three hundred per cent of the federal poverty level. The waiver
557 submitted by the commissioner shall specify that funding for such
558 health insurance coverage shall be provided through a reallocation of
559 unspent state children's health insurance plan funds.

560 Sec. 11. Section 17b-282b of the general statutes is repealed and the
561 following is substituted in lieu thereof (*Effective July 1, 2007*):

562 [(a) Not later than July 1, 2004, and prior to the implementation of a
563 state-wide dental plan that provides for the administration of the
564 dental services portion of the department's medical assistance, the
565 Commissioner of Social Services shall amend the federal waiver
566 approved pursuant to Section 1915(b) of the Social Security Act. Such
567 waiver amendment shall be submitted to the joint standing committees
568 of the General Assembly having cognizance of matters relating to
569 human services and appropriations and the budgets of state agencies
570 in accordance with the provisions of section 17b-8.

571 (b) Prior to the implementation of a state-wide dental plan that
572 provides for the administration of the dental services portion of the
573 department's medical assistance program, the Commissioner of Social
574 Services shall review eliminating prior authorization requirements for
575 basic and routine dental services. In the event the commissioner adopts
576 regulations to eliminate such prior authorization requirements, the

577 commissioner may implement policies and procedures for the
578 purposes of this subsection while in the process of adopting such
579 regulations, provided the commissioner prints notice of intention to
580 adopt the regulations in the Connecticut Law Journal not later than
581 twenty days after implementing the policies and procedures.]

582 (a) The Commissioner of Social Services shall establish a fee
583 schedule for dental services provided to individuals who are eligible
584 for medical assistance under section 17b-261, as amended by this act,
585 or section 17b-292, as amended by this act. The schedule shall provide
586 for a fee for each dental service provided on or after July 1, 2007,
587 except for an orthodontic service, that is equal to the seventieth
588 percentile of normal and customary private provider fees, as defined
589 by the National Dental Advisory Service Comprehensive Fee Report.
590 The schedule shall provide for a fee for each orthodontic service,
591 which may be less than the seventieth percentile of normal and
592 customary private provider fees, as defined by the National Dental
593 Advisory Service Comprehensive Fee Report.

594 (b) The Commissioner of Social Services shall evaluate whether the
595 fee schedule established pursuant to subsection (a) of this section
596 results in improved access to oral health care for medical assistance
597 recipients under the age of nineteen, as measured by (1) the number of
598 providers currently registered to provide dental services under the
599 medical assistance program described in section 17b-261, (2) the
600 number of medical assistance recipients under the age of nineteen
601 currently receiving such services, (3) the increase in the number of
602 providers registered to provide such services, (4) the increase in the
603 number of medical assistance recipients under the age of nineteen
604 receiving such services, (5) the number of new providers registered to
605 provide such services, and (6) the number of medical assistance
606 recipients under the age of nineteen receiving such services from
607 newly registered providers. The commissioner shall submit a report of
608 the evaluation, along with any recommendations, not later than
609 December 31, 2009, to the joint standing committees of the General
610 Assembly having cognizance of matters relating to human services and

611 public health, in accordance with the provisions of section 11-4a.

612 Sec. 12. (NEW) (*Effective July 1, 2007*) The Commissioner of Social
613 Services shall reimburse providers of medical services under the
614 medical assistance program, operated in accordance with section 17b-
615 261 of the general statutes, as amended by this act, at a rate that is
616 equal to the rate paid for the provision of such services under the
617 Medicare program.

618 Sec. 13. Section 19a-88 of the general statutes is amended by adding
619 subsection (g) as follows (*Effective from passage*):

620 (NEW) (g) On or before October 1, 2007, the Department of Public
621 Health shall establish and implement a secure on-line license renewal
622 system for persons holding a license to practice medicine or surgery
623 under chapter 370, dentistry under chapter 379 or nursing under
624 chapter 378. The department shall allow any such person who renews
625 his or her license using the on-line license renewal system to pay his or
626 her professional service fees on-line by means of a credit card or
627 electronic transfer of funds from a bank or credit union account and
628 may charge such person a service fee not to exceed five dollars for any
629 such on-line payment made by credit card or electronic funds transfer.

630 Sec. 14. Section 38a-497 of the general statutes is repealed and the
631 following is substituted in lieu thereof (*Effective July 1, 2007*):

632 Every individual health insurance policy providing coverage of the
633 type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of
634 section 38a-469 delivered, issued for delivery, amended or renewed in
635 this state on or after October 1, [1982] 2007, shall provide that coverage
636 of a child shall terminate no earlier than the policy anniversary date on
637 or after whichever of the following occurs first, the date on which the
638 child marries, ceases to be a [dependent of the policyholder,] resident
639 of the state or attains the age of [nineteen if the child is not a full-time
640 student at an accredited institution, or attains the age of twenty-three if
641 the child is a full-time student at an accredited institution] thirty.

642 Sec. 15. Section 38a-554 of the general statutes is repealed and the
643 following is substituted in lieu thereof (*Effective July 1, 2007*):

644 A group comprehensive health care plan shall contain the minimum
645 standard benefits prescribed in section 38a-553 and shall also conform
646 in substance to the requirements of this section.

647 (a) The plan shall be one under which the individuals eligible to be
648 covered include: (1) Each eligible employee; (2) the spouse of each
649 eligible employee, who shall be considered a dependent for the
650 purposes of this section; and (3) [dependent] unmarried children
651 residing in the state, who are under [the age of nineteen or are full-
652 time students under the age of twenty-three at an accredited institution
653 of higher learning] thirty years of age.

654 (b) The plan shall provide the option to continue coverage under
655 each of the following circumstances until the individual is eligible for
656 other group insurance, except as provided in subdivisions (3) and (4)
657 of this subsection: (1) Notwithstanding any provision of this section,
658 upon layoff, reduction of hours, leave of absence, or termination of
659 employment, other than as a result of death of the employee or as a
660 result of such employee's "gross misconduct" as that term is used in 29
661 USC 1163(2), continuation of coverage for such employee and such
662 employee's covered dependents for the periods set forth for such event
663 under federal extension requirements established by the federal
664 Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272),
665 as amended from time to time, (COBRA), except that if such reduction
666 of hours, leave of absence or termination of employment results from
667 an employee's eligibility to receive Social Security income,
668 continuation of coverage for such employee and such employee's
669 covered dependents until midnight of the day preceding such person's
670 eligibility for benefits under Title XVIII of the Social Security Act; (2)
671 upon the death of the employee, continuation of coverage for the
672 covered dependents of such employee for the periods set forth for such
673 event under federal extension requirements established by the
674 Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272),

675 as amended from time to time, (COBRA); (3) regardless of the
676 employee's or dependent's eligibility for other group insurance, during
677 an employee's absence due to illness or injury, continuation of
678 coverage for such employee and such employee's covered dependents
679 during continuance of such illness or injury or for up to twelve months
680 from the beginning of such absence; (4) regardless of an individual's
681 eligibility for other group insurance, upon termination of the group
682 plan, coverage for covered individuals who were totally disabled on
683 the date of termination shall be continued without premium payment
684 during the continuance of such disability for a period of twelve
685 calendar months following the calendar month in which the plan was
686 terminated, provided claim is submitted for coverage within one year
687 of the termination of the plan; (5) the coverage of any covered
688 individual shall terminate: (A) As to a child, the plan shall provide the
689 option for said child to continue coverage for the longer of the
690 following periods: (i) At the end of the month following the month in
691 which the child marries, ceases to [be dependent on the employee]
692 reside in the state or attains the age of [nineteen, whichever occurs
693 first, except that if the child is a full-time student at an accredited
694 institution, the coverage may be continued while the child remains
695 unmarried and a full-time student, but not beyond the month
696 following the month in which the child attains the age of twenty-three]
697 thirty. If on the date specified for termination of coverage on a
698 [dependent] child, the child is unmarried and incapable of self-
699 sustaining employment by reason of mental or physical handicap and
700 chiefly dependent upon the employee for support and maintenance,
701 the coverage on such child shall continue while the plan remains in
702 force and the child remains in such condition, provided proof of such
703 handicap is received by the carrier within thirty-one days of the date
704 on which the child's coverage would have terminated in the absence of
705 such incapacity. The carrier may require subsequent proof of the
706 child's continued incapacity and dependency but not more often than
707 once a year thereafter, or (ii) for the periods set forth for such child
708 under federal extension requirements established by the Consolidated
709 Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended

710 from time to time, (COBRA); (B) as to the employee's spouse, at the
711 end of the month following the month in which a divorce, court-
712 ordered annulment or legal separation is obtained, whichever is
713 earlier, except that the plan shall provide the option for said spouse to
714 continue coverage for the periods set forth for such events under
715 federal extension requirements established by the Consolidated
716 Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended
717 from time to time, (COBRA); and (C) as to the employee or dependent
718 who is sixty-five years of age or older, as of midnight of the day
719 preceding such person's eligibility for benefits under Title XVIII of the
720 federal Social Security Act; (6) as to any other event listed as a
721 "qualifying event" in 29 USC 1163, as amended from time to time,
722 continuation of coverage for such periods set forth for such event in 29
723 USC 1162, as amended from time to time, provided such plan may
724 require the individual whose coverage is to be continued to pay up to
725 the percentage of the applicable premium as specified for such event in
726 29 USC 1162, as amended from time to time. Any continuation of
727 coverage required by this section except subdivision (4) or (6) of this
728 subsection may be subject to the requirement, on the part of the
729 individual whose coverage is to be continued, that such individual
730 contribute that portion of the premium the individual would have
731 been required to contribute had the employee remained an active
732 covered employee, except that the individual may be required to pay
733 up to one hundred two per cent of the entire premium at the group
734 rate if coverage is continued in accordance with subdivision (1), (2) or
735 (5) of this subsection. The employer shall not be legally obligated by
736 sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, to pay such
737 premium if not paid timely by the employee.

738 (c) The commissioner shall adopt regulations, in accordance with
739 chapter 54, concerning coordination of benefits between the plan and
740 other health insurance plans.

741 (d) The plan shall make available to Connecticut residents, in
742 addition to any other conversion privilege available, a conversion
743 privilege under which coverage shall be available immediately upon

744 termination of coverage under the group plan. The terms and benefits
745 offered under the conversion benefits shall be at least equal to the
746 terms and benefits of an individual comprehensive health care plan.

747 Sec. 16. (NEW) (*Effective July 1, 2007*) eHealth Connecticut shall be
748 designated the lead health information exchange organization for the
749 state of Connecticut for the period commencing July 1, 2007, and
750 ending July 1, 2012. The Commissioner of Public Health shall contract
751 with such organization to develop a state-wide health information
752 technology plan, which includes development of standards, protocols
753 and pilot programs for health information exchange.

754 Sec. 17. (*Effective from passage*) Not later than January 1, 2008, the
755 Department of Social Services shall inventory and report, in
756 accordance with the provisions of section 11-4a of the general statutes,
757 on all disease management initiatives implemented as of the effective
758 date of this section under the HUSKY Plan, Part A, the HUSKY Plan,
759 Part B, the state-administered general assistance program and the state
760 Medicaid plan to the joint standing committees of the General
761 Assembly having cognizance of matters relating to public health and
762 human services. Such report shall include a summary of each
763 initiative, the total amount of money spent on each initiative, from
764 inception, and the total number of persons served by each initiative.

765 Sec. 18. (*Effective from passage*) Not later than January 1, 2008, the
766 Department of Public Health shall inventory and report, in accordance
767 with section 11-4a of the general statutes, on all public and private
768 sector disease management programs within the state as of the
769 effective date of this section, except for disease management initiatives
770 described in section 17 of this act, to the joint standing committee of
771 the General Assembly having cognizance of matters relating to public
772 health. Such inventory shall include (1) a summary of each program,
773 (2) the amount of money spent on each program, (3) the number of
774 persons being served in each program, and (4) recommendations about
775 best practices for disease management programs and how to replicate
776 such best practices state-wide.

777 Sec. 19. (NEW) (*Effective from passage*) (a) There is established a
778 health care panel composed of the following members: Two appointed
779 by the speaker of the House of Representatives, one of whom is a
780 health care provider; two appointed by the president pro tempore of
781 the Senate, one of whom represents managed care organizations; one
782 appointed by the majority leader of the House of Representatives who
783 represents health insurance companies; one appointed by the majority
784 leader of the Senate who represents businesses with fewer than fifty
785 employees; one appointed by the minority leader of the House of
786 Representatives who represents businesses with fifty or more
787 employees; one appointed by the minority leader of the Senate with
788 experience in community-based health care; the Commissioners of
789 Public Health and Social Services or their designees; and two persons
790 appointed by the Governor, one of whom represents hospitals and one
791 of whom advocates for health care quality or patient safety.

792 (b) All appointments to the panel shall be made not later than thirty
793 days after the effective date of this section. Any vacancy shall be filled
794 by the appointing authority.

795 (c) The speaker of the House of Representatives and the president
796 pro tempore of the Senate shall select the chairpersons of the panel,
797 from among the members of the panel. Such chairpersons shall
798 schedule the first meeting of the task force, which shall be held not
799 later than sixty days after the effective date of this section.

800 (d) The panel shall:

801 (1) Examine and evaluate policy alternatives for providing health
802 insurance coverage for individuals residing in this state who are
803 uninsured or underinsured such as premium assistance programs,
804 individual mandates for coverage, employer mandates for coverage
805 and a state-wide single payer health care system.

806 (2) Not later than January 1, 2009, report on its findings and
807 recommendations with respect to such policy alternatives to the joint
808 standing committee of the General Assembly having cognizance of

809 matters relating to public health, social services and insurance, in
810 accordance with the provisions of section 11-4a of the general statutes.
811 Such report shall include recommended strategies for increasing access
812 to health care for all of Connecticut's residents.

813 (e) The panel may collect data on and promote wellness, nutrition,
814 disease prevention and exercise among Connecticut residents.

815 Sec. 20. Section 38a-1041 of the general statutes is amended by
816 adding subsection (f) as follows (*Effective October 1, 2007*):

817 (NEW) (f) On or before October 1, 2008, the Office of the Healthcare
818 Advocate shall, within available appropriations, establish and
819 maintain a healthcare consumer information web site on the Internet
820 for use by the public in obtaining healthcare information, including but
821 not limited to: (1) The availability of wellness programs in various
822 regions of Connecticut, such as disease prevention and health
823 promotion programs; (2) quality and experience data from hospitals
824 licensed in this state; and (3) a link to the consumer report card
825 developed and distributed by the Insurance Commissioner pursuant to
826 section 38a-478l.

827 Sec. 21. (NEW) (*Effective October 1, 2007*) Any employer that
828 provides health insurance benefits to its employees for which any
829 portion of the premiums are deducted from the employees' pay shall
830 offer such employees the opportunity to have such portion excluded
831 from their gross income for state or federal income tax purposes,
832 except as required under Section 125 of the Internal Revenue Code of
833 1986, or any subsequent corresponding internal revenue code of the
834 United States, as from time to time amended.

835 Sec. 22. (NEW) (*Effective from passage*) The committee established
836 under section 51 of public act 06-195 shall meet at least once every
837 calendar quarter and report annually to the joint standing committees
838 of the General Assembly having cognizance of matters relating to
839 public health and education, in accordance with the provisions of
840 section 11-4a of the general statutes, on recommended statutory and

841 regulatory changes to improve health care through access to school-
842 based health clinics.

843 Sec. 23. (NEW) (*Effective July 1, 2007*) Any school-based health clinic
844 constructed on or after October 1, 2007, that is located in or attached to
845 a school building shall be constructed with an entrance that is separate
846 from the entrance to the school building.

847 Sec. 24. (*Effective July 1, 2007*) The sum of two million five hundred
848 thousand dollars is appropriated to the Department of Public Health,
849 from the General Fund, for the fiscal year ending June 30, 2008, for the
850 expansion and operation of school-based health clinics for priority
851 school districts pursuant to section 10-266p of the general statutes and
852 areas designated by the federal Health Resources and Services
853 Administration as health professional shortage areas, medically
854 underserved areas or areas with a medically underserved population.

855 Sec. 25. (*Effective July 1, 2007*) The sum of five hundred thousand
856 dollars is appropriated to the Department of Public Health, from the
857 General Fund, for the fiscal year ending June 30, 2008, for grants to
858 community-based health centers to provide transportation assistance
859 to patients for medical appointments. Priority shall be given to
860 federally-qualified health centers located in areas of the state with
861 limited public transportation options.

862 Sec. 26. (*Effective July 1, 2007*) The sum of two million dollars is
863 appropriated to the Department of Public Health, from the General
864 Fund, for the fiscal year ending June 30, 2008, for grants to community-
865 based health centers for infrastructure improvements, including, but
866 not limited to, health information technology.

867 Sec. 27. Section 17b-261c of the general statutes is repealed. (*Effective*
868 *July 1, 2007*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2007</i>	17b-28e

Sec. 2	<i>July 1, 2007</i>	17b-261
Sec. 3	<i>July 1, 2007</i>	17b-297
Sec. 4	<i>July 1, 2007</i>	17b-297b
Sec. 5	<i>July 1, 2007</i>	New section
Sec. 6	<i>July 1, 2007</i>	17b-289
Sec. 7	<i>July 1, 2007</i>	17b-292
Sec. 8	<i>July 1, 2007</i>	17b-192
Sec. 9	<i>July 1, 2007</i>	17b-277(a)
Sec. 10	<i>July 1, 2007</i>	New section
Sec. 11	<i>July 1, 2007</i>	17b-282b
Sec. 12	<i>July 1, 2007</i>	New section
Sec. 13	<i>from passage</i>	19a-88
Sec. 14	<i>July 1, 2007</i>	38a-497
Sec. 15	<i>July 1, 2007</i>	38a-554
Sec. 16	<i>July 1, 2007</i>	New section
Sec. 17	<i>from passage</i>	New section
Sec. 18	<i>from passage</i>	New section
Sec. 19	<i>from passage</i>	New section
Sec. 20	<i>October 1, 2007</i>	38a-1041
Sec. 21	<i>October 1, 2007</i>	New section
Sec. 22	<i>from passage</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>	New section
Sec. 26	<i>July 1, 2007</i>	New section
Sec. 27	<i>July 1, 2007</i>	Repealer section

PH *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: See below

Municipal Impact: See below

Explanation

This bill makes various changes to the Department of Social Services' (DSS) health care programs. The quantifiable costs of these changes are \$1,147,175,000 in FY08 and \$1,216,335,000 in FY09. The majority of these costs would be reimbursable at varying levels by the federal government, as detailed below.

Section 1 requires DSS to amend the state Medicaid plan to include foreign language interpreting services. The cost of this change will be dependent upon the structure of the service included in the state plan amendment. Estimates of providing this service have ranged up to \$4,700,000 annually for face to face interpreters. These costs would be reimbursed 50% by the federal government under the Medicaid program.

Section 2 expands eligibility for parents of children enrolled in the HUSKY A program from 150% of the federal poverty level (FPL) to 185% FPL. The Office of Fiscal Analysis (OFA) estimates that this will add an additional 9,700 clients to the program when fully annualized, at a cost of \$23,500,000 in FY08 and \$31,300,000 in FY09. This estimate includes the rate increases implemented in section 12 of the bill. These costs would be reimbursed 50% by the federal government under the Medicaid program.

Section 2 also requires DSS to increase the Medicaid medically needy income limit to 185% FPL. This change is expected increase Medicaid eligibility by 43,200 individuals, at a cost of \$214,700,000 in

FY08 and \$227,500,000 in FY09. These costs would be reimbursed 50% by the federal government under the Medicaid program.

Section 2 also eliminates certain cost sharing requirements for parents in HUSKY A. As this policy was never implemented, this provision has no fiscal impact.

Section 3 of the bill requires DSS to increase outreach and maximize enrollment of eligible children and adults in the HUSKY programs. Increased outreach will result in increased administrative costs, the extent of which is dependent upon the outreach mechanisms used. Should such outreach efforts succeed, additional enrollment in these programs would result in additional state costs.

Section 4 requires boards of education to provide HUSKY outreach materials to parents and guardians of students at the beginning of each school year. There is no increased cost for these boards as the information would be disseminated through the existing practices for school notices. DSS will incur administrative costs to prepare the materials for the approximately 562,000 students in 1,000 separate schools. Should such outreach efforts succeed, additional enrollment in these programs would result in additional state costs.

Section 5 requires DSS, in consultation with the Department of Public Health, to establish and implement a multi-year, statewide public information campaign to promote HUSKY enrollment. DSS must solicit bids from private organizations to design and operate the campaign. This will result in significant increased costs to DSS, the extent of which will depend upon the scope and design of the campaign. Should such outreach efforts succeed, additional enrollment in these programs would result in additional state costs.

Sections 6 and 7 require DSS to establish a centralized unit responsible for processing all HUSKY (both A and B) applications. This change is expected to streamline the application processes for HUSKY A and HUSKY B, and will provide eligible clients with more continuous medical coverage. DSS will incur additional

administrative costs to centralize these processes, but may also incur offsetting administrative savings through a reduction in unnecessary reapplications.

Sections 7 and 27 also re-establish the continuous eligibility policy for children in the HUSKY plan. Assuming the rate increases included in section 12, this change is estimated to cost \$2,800,000 annually. These costs would be reimbursed 50% by the federal government under the Medicaid program. The bill also establishes a continuous eligibility policy for adults in the HUSKY programs. This change is estimated to cost approximately \$925,000 annually. Based on current federal policy, it does not appear that these funds will be federally reimbursable.

Section 8 increases eligibility for the State Administered General Assistance (SAGA) to 100% FPL. OFA estimates that this increase will serve an additional 22,000 individuals, at a cost to DSS of \$105,000,000 in FY08 and \$111,300,000 in FY09. Should the General Assistance Managed Care program under the Department of Mental Health and Addiction Services receive a proportional increase, the total cost of this expansion would be \$160,100,000 in FY08 and \$169,700,000 in FY09. These estimates assume that the current service structure and benefit package in the SAGA program remains in place.

This section further directs DSS to seek a federal waiver to enroll SAGA clients within the Medicaid program. Currently, the state receives federal reimbursement for a portion of SAGA hospital costs under the Disproportionate Share Hospital program. A waiver enrolling SAGA clients into Medicaid would enable the state to receive a 50% reimbursement on all SAGA medical costs. The impact of this would depend upon the conditions of the federal waiver. Should the state be able to enroll all SAGA clients in Medicaid while retaining the current program structure and benefits, the additional federal funds would basically offset the SAGA expansion costs noted above. However, as the Medicaid benefits package is richer than the SAGA package, and is provided on a full entitlement basis, the federal

government, if they choose to accept such a waiver, may require the state to make significant changes to the SAGA program. Therefore, the net impact of this proposal is not known.

Sections 9 and 10 expand Medicaid coverage for pregnant women from 185% FPL to 300% FPL, and require DSS to seek an SCHIP waiver for this expanded population. OFA estimates that this expansion would cost \$5,000,000 in FY08 and \$5,300,000 in FY09, assuming the rate increases implemented in section 12. These costs would be eligible for 50% federal reimbursement (65% if the federal government approves the SCHIP waiver).

Sections 11 and 12 increase Medicaid rates. Section 12 specifies that DSS shall reimburse providers of medical services under the Medicaid program at the rate that is paid under the Medicare program. Although the bill does not specify, it is assumed that rates for both HUSKY and the Medicaid fee-for-service program will be increased.

It should first be noted that DSS does not directly reimburse medical providers under the HUSKY programs. The Department pays a capitated rate to managed care organizations (MCO's), who then reimburse medical providers in their systems. Secondly, given the disparate populations served (HUSKY is predominantly women and children, while Medicare serves the elderly and disabled), there may not be Medicare rates that correspond with HUSKY rates. Also, rates paid by the MCO's to providers in their system are not available as they are considered proprietary.

Assuming that DSS was to implement the provisions of this section by increasing the rates under Medicaid fee-for-service, the behavioral health partnership and the capitated rates paid to the HUSKY MCO's, OFA estimates that this would cost approximately \$711,000,000 in FY08 and \$753,700,000 in FY09. Of this increase, \$326,700,000 in FY08 and \$345,800,000 in FY09 is attributable to the HUSKY programs. As stated above, exact comparisons between current HUSKY rates and Medicare rates are not possible. Based on data included in the Office of Health Care Access' 2005 Annual Report on the financial status of

Connecticut’s hospitals, it would require a 38% Medicaid rate increase to match the hospital rates paid under the Medicare program. As reliable data does not exist for rate comparisons, OFA used this 38% rate increase as a proxy. The increases cited above would be eligible for federal reimbursement under the Medicaid and SCHIP programs, which would generate estimated General Fund revenue of \$357,200,000 in FY08 and \$379,100,000 in FY09.

Section 11 also requires that the reimbursement to dental providers under the HUSKY program be equal to the 70th percentile of the normal and customary fee, as defined by the National Dental Advisory Service Comprehensive Fee Report. Based on the latest such fee report, OFA estimates that this increase would cost \$27,000,000 annually over the current HUSKY dental expenditures. It would represent a \$20,000,000 increase over the Medicaid to Medicare rate increases calculated above. These costs would be reimbursed 50% by the federal government under the Medicaid program. The bill also requires DSS to assess access to dental services and report to the General Assembly by December 31, 2008.

The rate increases included in sections 11 and 12 of the bill may lead to increased access to services as provider may be more willing to serve HUSKY and Medicaid clients. Should this be the case, it is likely that the MCO’s would seek a future increase in their capitated rates to compensate for this change. It is not known what this increased utilization may be. However, any increased utilization in either the HUSKY or Medicaid fee-for-service programs will result in significant increased state costs. For example, a 5% increased utilization for all services would result in increased costs of \$118,000,000 annually.

Section 13 requires the DPH to establish an on-line license renewal system for physicians, nurses and dentists by 10/1/07. The agency will incur an FY 08 cost of approximately \$3,700,000 to implement an on-line license system by this date. This includes:

One-time costs of creating a platform necessary to support the new licensing system	\$1,200,000
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One-time costs of purchasing and customizing a web based licensure application and database system	\$1,500,000
One-time consultant charges related to staff training	\$724,000
Department of Information Technology (DoIT) hosting fees	\$180,000
Software license/maintenance fees	\$50,000
Conveyance Fees (re: processing credit card payments)	\$60,000
Total - Year 1 Costs	\$3,714,000

An FY 09 cost of \$410,000 would be incurred, associated with ongoing DoIT hosting, license/maintenance, and conveyance fees as well as second year consultant charges (\$120,000). Commencing in FY 10, costs would fall to \$290,000 annually as the consultant services would no longer be required.

It should be noted that HB 7077 (the Governor's recommended FY 08 - FY 09 Biennial Budget), includes \$1,170,000 in FY 09 to support costs of initiating implementation of an on-line licensure system.

Sections 14 and 15, by requiring insurance policies that cover dependent children to provide coverage until the age of 30 (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 30 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.

Section 16: The Department of Public Health will incur an

approximate cost of \$750,000 to contract with eHealth Connecticut to develop a statewide health information technology plan. Additional indeterminate costs would be incurred to further develop and/or implement standards, protocols and/or pilot programs.

Section 17 requires DSS to inventory all disease management programs implemented under the HUSKY, SAGA and Medicaid programs. DSS must report the findings of this inventory to the General Assembly by January 1, 2008. This will result in a minor administrative cost to the agency.

Section 18: The DPH will incur a one-time cost of approximately \$30,000 in FY 08 to compile an inventory of all public and private disease management programs, other than those administered by the DSS, by 1/1/08.

Section 19: It is anticipated that representatives of the DPH and DSS can participate in the activities of the panel to evaluate health insurance coverage policy alternatives within each agency's normally budgeted resources.

Section 20 of the bill would result in a cost to the Office of the Healthcare Advocate (OHA) for additional staff resources to create and maintain a website for consumer health care information. OHA would require a technical consultant to design and create the website. Costs would only be in FY 08, since existing staff would maintain the website, as needed.

Detailed costs appear in the table below:

Item:	FY 08
Consultant	\$25,000
Licensing & access fees	\$10,000
Total	\$35,000

Since the bill requires these provisions to be implemented within available appropriations, the agency would have to redirect existing

resources in order to comply.

Section 21 requires that employers allow employees to make health insurance premium payments with pre-tax dollars. As this is the current practice for the state as an employer, there is no fiscal impact.

Section 22 requires the Ad Hoc Committee to Improve Health Care Access through School Based Health Centers to meet at least quarterly, and report annually, to the Public Health and Education Committees. No cost is anticipated to result, as members are not entitled to reimbursement for expenses.

Section 23 requires any newly constructed school based health center (SBHC) to have a separate entrance, on and after 10/1/07. It is anticipated that resulting local costs, if any, will be factored into the decision making process of local education authorities or municipal officials when evaluating proposed SBHC development. Since the state does not routinely provide financial support for SBHC related capital costs, no state fiscal impact is anticipated.

Section 24 appropriates \$2,500,000 to the DPH for FY 08 to expand and operate SBHC's in priority school districts and areas (federally) designated as health professional shortage areas, medically underserved areas or with a medically underserved population. A potential municipal revenue gain would ensue to the extent that eligible communities receive a portion of this funding.

Section 25 appropriates \$500,000 to the DPH for FY 08 for grants to community-based health centers to provide transportation assistance to patients.

Section 26 appropriates \$2,000,000 to the DPH for FY 08 for grants to community-based health centers for infrastructure improvements.

The Out Years

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

OLR Bill Analysis**sSB 1*****AN ACT CONCERNING THE HEALTHFIRST CONNECTICUT INITIATIVE.*****SUMMARY:**

This bill expands access to public health insurance by making a number of changes in the HUSKY, Medicaid, and State-Administered General Assistance (SAGA) programs. Among other changes it:

1. raises the income limit for HUSKY A (Medicaid) coverage for caretaker relatives and pregnant women;
2. restores continuous eligibility for children enrolled in HUSKY A or B and adds it for adults;
3. requires (a) the Department of Social Services (DSS) to establish a dental provider fee schedule for services to anyone enrolled in HUSKY or Medicaid and (b) all Medicaid providers to be reimbursed for services at the same rate Medicare pays; and
4. requires DSS to increase the income limit for the SAGA medical assistance program and seek a federal waiver to convert the program from a fully state-funded program to a Medicaid-funded one.

The bill extends, from age 23 to 30, the age to which group comprehensive and individual health insurance policies that cover dependent children must do so, and it requires employers to offer employees a chance to pay their health insurance premiums with pre-tax dollars (section 125 plans). It creates a panel to study ways to provide health coverage to un- and under-insured state residents. It requires DSS and the Department of Public Health (DPH) to inventory

public and private disease management program.

It designates a nonprofit corporation as the state's electronic health information exchange, requires DPH to develop an electronic license renewal system for certain professions, and requires the healthcare advocate to create a consumer health information website.

Finally, it appropriates funds for various school- and community-based health center operations.

EFFECTIVE DATE: July 1, 2007, except for the provisions concerning (a) on-line license renewal, DSS and DPH disease management inventories, the health care panel, and extension of the school-based health center committee, which are effective upon passage, and (b) the consumer health information website and section 125 plans, which are effective October 1, 2007.

HUSKY

Increase Income Limit for HUSKY A Coverage for Adult Caretaker Relatives; Eliminate Cost Sharing in HUSKY A (§ 2)

The bill increases, from 150% to 185% of the federal poverty level (FPL, from \$25,755 to \$31,764 annually for a family of three in 2007) the income limit for HUSKY A adult caretaker coverage. This higher limit already applies to children applying for or enrolled in the HUSKY A program.

The bill requires the DSS commissioner, when individuals or families apply for Medicaid coverage, to advise them of the (1) effect that having income over the limit has on program eligibility and (2) availability of HUSKY B for those ineligible for HUSKY A. (HUSKY B provides virtually identical subsidized medical coverage to children in families whose income is between 185% and 300% of the FPL.)

The bill repeals a never-implemented requirement that DSS make HUSKY A caretaker relatives with incomes above 100% of the FPL pay cost sharing, including premiums and co-payments, as allowed by federal law or waivers.

Continuous Eligibility (§§ 7 & 27)

The bill provides that any child determined eligible for HUSKY A or B, and any adult caretaker eligible for HUSKY A, must remain eligible for 12 months from the initial eligibility determination date, unless they are no longer state residents, or, in the case of the child, the child turns 19. During this period of continuous eligibility, the family must comply with federal requirements concerning the reporting of information to DSS, including change of address information. Currently, families must report changes in financial circumstances within the 12-month period, which can render the child, adult, or both ineligible for assistance. Federal law does not appear to allow adults to be continuously eligible for Medicaid without a waiver. The bill's passage could affect the state's eligibility for federal matching funds.

The bill makes a corollary change by repealing a separate provision that prohibits adults enrolled in HUSKY A from being guaranteed eligibility for six months without regard to changes in circumstances that would otherwise render them ineligible. Federal law allows states to guarantee continuous enrollment of adults in Medicaid managed care for the first six months they are enrolled in a plan.

Although, under the bill, children remain continuously eligible for HUSKY, the bill requires DSS within 10, instead of 12, months from its HUSKY eligibility determination to determine if the child will continue to qualify once the 12-month period ends. It requires DSS, if a HUSKY beneficiary requests, to send renewal applications electronically instead of automatically mailing a renewal form, which the law continues to require if no request is made.

Coverage for Pregnant Women (§§ 9 & 10)

The bill requires DSS to increase the income limit for HUSKY A coverage for pregnant women from 185% to 300% of the FPL (\$3,422 per month for two-person household). It requires DSS to seek a federal Health Insurance Flexibility and Accountability demonstration waiver to cover these women. The waiver must specify that the expanded coverage will be provided through a re-allocation of the state's

unspent State Children's Health Insurance Program (SCHIP) block grant funds. (Federal Medicaid funds match the state's payments for the coverage for women with incomes under 185% of the FPL.)

Dental Coverage (§ 11)

The bill requires the DSS commissioner to establish a fee schedule for dental services provided to all individuals eligible for HUSKY A, other Medicaid programs, or HUSKY B. The schedule, applicable for each dental service other than orthodontia provided on and after July 1, 2007, must provide for a fee equal to the 70th percentile of normal and customary private provider fees, as defined by the National Dental Advisory Service Comprehensive Fee Report. The schedule must provide for a fee for orthodontic services, which can be less than the 70th percentile.

The commissioner must evaluate whether the schedule results in improved access to oral health care for "medical assistance recipients under the age of 19" (presumably, children enrolled in HUSKY or other Medicaid). The evaluation must look at (1) the current number of providers registered to provide Medicaid dental services and children served (2) any increase in the number of providers and children served, and (3) the number of children receiving services from newly registered providers. By December 31, 2009, the commissioner must submit the evaluation and any recommendations to the Human Services and Public Health committees.

Under current practice, DSS maintains a pediatric dental fee schedule, but it is not used because children in HUSKY receive all medical services through the managed care organizations (MCO) that contract with DSS. The MCOs subcontract with dental providers, including managed care plans, for these services and these plans set the reimbursement rates that the dental providers receive. DSS' current pediatric dental fees fall well below the 70th percentile.

Outreach (§§ 3, 4, & 5)

DSS Requirements. The bill requires DSS, in consultation with the

Children's Health Council (defunct), the Medicaid Managed Care Council, and 2-1-1 Infoline, to develop ways to increase outreach and maximize enrollment of children and adults in HUSKY. Under current law, they must develop outreach. The mechanisms must include developing and implementing an on-line application. Current law requires, and DSS already has, a mail-in application.

The bill adds the Mental Health and Addiction Services, Mental Retardation, Education, and Motor Vehicles departments to the list of agencies with which DSS must collaborate to disseminate outreach materials. It eliminates a requirement that the commissioner include in the outreach efforts information on the Medicaid program for purposes of maximizing the enrollment of eligible children and the use of federal funds.

By law, the DSS commissioner, within available appropriations, must contract with severe need schools (poor schools located in priority or former priority districts) and community-based organizations for purposes of public education, outreach, and recruitment of HUSKY-eligible children. The bill extends this to include also HUSKY-eligible adults.

Current law requires DSS to report annually to the governor on its community-based outreach program. Starting January 1, 2008, this report must also go to the Human Services, Public Health, and Appropriations committees, and it must be on all outreach efforts, not just community-based ones.

School District Requirements. The bill requires each local or regional board of education or similar body governing a nonpublic school to provide HUSKY eligibility outreach materials to parents and guardians of students at the beginning of each school year. DSS must develop these materials and disseminate them to the schools.

Multi-Year, Statewide Information Campaign. The bill requires DSS, in consultation with DPH, to create a joint, public-private program to establish and implement a multi-year, statewide public

information campaign to promote HUSKY enrollment.

The bill requires DSS to consult with DPH and solicit bids from private organizations to design and operate the campaign, regardless of any contrary provision in the personal service agreement law (see BACKGROUND). The bids must be solicited by sending notice to prospective bidders and posting notice on public bulletin boards within the departments. The bids must be opened publicly at the time the solicitation states. The departments' acceptance of a bid must be based on standard specifications they adopt. The bill allows DSS to accept gifts, donations, bequests, grants, or funds from public or private agencies for the campaign.

Starting January 1, 2008, DSS must annually report to the Human Services, Public Health, and Appropriations committees on the campaign's status.

Central DSS Unit for Processing and Marketing Applications (§ 7)

The bill requires DSS, in consultation with the servicer (enrollment broker with which DSS contacts, currently ACS, Inc.), to establish a centralized unit to be responsible for processing all HUSKY applications. DSS, through its contract, must ensure that a child determined eligible for HUSKY has uninterrupted coverage for as long as the parent or guardian elects to enroll or re-enroll the child.

The bill requires DSS in consultation with the servicer, instead of the servicer alone, to jointly market the HUSKY A and B as one program. And it requires the servicer to electronically send HUSKY A, as well as HUSKY B, enrollment and disenrollment data to DSS.

The bill makes it clear that the servicer sends DSS all HUSKY applications, not just those for children with family income of 185% of FPL or less.

OTHER MEDICAID

Increase Income Limit for Medically Needy Individuals (§ 2)

The bill requires the DSS commissioner to file a Medicaid State Plan

amendment to allow him to raise the income limit for aged, blind, and disabled individuals applying for and receiving coverage under the Medicaid medically needy coverage group. He must establish a special income disregard, which when applied, will have the effect of raising the income limit to the same limit that applies to HUSKY A caretaker relatives (150% of FPL currently but raised to 185% under the bill). Currently, the medically needy income limit for one person is \$476 per month. Under the bill, it would effectively rise to \$1,574 per month at the 185% of FPL level.

Medicaid Coverage for SAGA Medical Assistance Recipients (§ 8)

The bill requires the DSS commissioner to increase the income limit for SAGA medical assistance recipients from the Medicaid medically needy income limit (currently \$476 per month for a single resident living in most parts of the state) to the FPL (presumably 100% of the FPL, or \$850 per month for this person). It requires DSS, by January 1, 2008, instead of March 1, 2004, to seek a federal Medicaid waiver to get Medicaid coverage for the SAGA medical assistance program.

The bill removes obsolete language pertaining to town-administered General Assistance medical assistance.

It eliminates the deadline (August 20, 2003) by which federally qualified health centers (FQHC) participating in the SAGA medical assistance program must enroll in the federal Office of Pharmacy Affairs Section 340B drug discount program.

Fees for All Medicaid Providers (§ 12)

The bill requires the DSS commissioner to reimburse all Medicaid providers for services at the same rate the Medicare program pays. The HUSKY A program is part of Medicaid, but providers are not paid by DSS but the MCOs. It is not clear whether DSS would be required to amend the MCO contracts to ensure these rates are paid. (The bill also establishes a dental fee schedule for medical assistance programs, including Medicaid. But since Medicare does not pay for dental services, this provision would not appear to conflict with the earlier

one.)

Medicaid Coverage for Foreign Language Interpreters (§ 1)

The bill requires the DSS commissioner to amend the Medicaid state plan to include foreign language interpreters as a covered service for Medicaid beneficiaries with limited English proficiency.

DEPENDENT CHILDREN COVERAGE EXTENSION (§§ 14 & 15)

The bill extends, from age 23 to 30, the age to which group comprehensive and individual health insurance policies that cover children must do so. Current law requires coverage for unmarried, dependent children until they turn 19, or 23 if the child is a full-time student at an accredited school. The bill eliminates the requirement that children be dependent and limits continuing coverage to those who live in Connecticut.

It applies to:

1. individual health insurance policies delivered, issued, amended, or renewed after September 30, 2007 that cover (a) basic hospital and medical surgical expenses, (b) major medical expenses, (c) accidents, (d) limited benefits, and (e) hospital or medical services; and
2. group comprehensive health care plans and plans continuing coverage after an employee's layoff, reduction of hours, leave of absence, or termination.

This coverage extension for these plans appears to apply beginning July 1, 2007.

PRE-TAX PREMIUM DEDUCTIONS (§ 21)

The bill requires every employer that deducts health insurance premiums from its employees' pay to give the employees the opportunity to make these payments with pre-tax dollars as permitted under IRS Code section 125.

HEALTH CARE STUDY (§ 19)

The bill creates a 12-member health care panel to evaluate alternatives for providing health insurance for un- and underinsured state residents such as premium assistance, individual and employer coverage mandates, and a single-payer system. The panel must report its recommended strategies by January 1, 2009 to the Public Health, Human Services, and Insurance committees. It can also collect data on, and promote, wellness, nutrition, disease prevention, and exercise among state residents.

Legislative leaders and the governor appoint 10 members some of whom must represent specific interests as Table 1 shows. The DPH and DSS commissioners are also panel members.

Table 1: Health Care Panel Appointments

<i>Appointing Authority Appointments</i>	<i>Appointee</i>
Governor (2)	<ul style="list-style-type: none"> • Health quality or patient safety advocate • Unspecified
Senate president pro tempore (2)	<ul style="list-style-type: none"> • Managed care organizations representative • Unspecified
House speaker (2)	<ul style="list-style-type: none"> • Health care provider • Unspecified
Senate majority leader (1)	Representative of businesses with fewer than 50 employees
House majority leader (1)	Health insurers representative
Senate minority leader (1)	Person with community health experience

House minority leader (1)	Representative of businesses with 50 or more employees
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All appointments must be made within 30 days after the bill is enacted. The appointing authority fills vacancies. The speaker and president pro tempore choose the chairpersons who must schedule the first panel's meeting no more than 60 day's after the bill's enactment.

DISEASE MANAGEMENT (§§ 17 & 18)

By January 1, 2008, the bill requires DSS and DPH to inventory public and private disease management initiatives implemented as of the date the bill passes. DSS must inventory initiatives in the HUSKY, SAGA medical assistance, and other Medicaid programs. DPH must inventory all other public and private programs. For each initiative and program, the report must include a summary, total spent, and number of people served. The DPH report must also include recommendations about best practices and ways to replicate them statewide. DSS must report to the Human Services and Public Health committees, DPH just to the Public Health Committee.

ELECTRONIC HEALTH RECORDS (§ 16)

The bill designates eHealth Connecticut, a nonprofit corporation, as the state's lead health information exchange organization from July 1, 2007 to July 1, 2012. It requires the DPH commissioner to contract with eHealth to develop a statewide health information technology plan that includes standards, protocols, and pilot programs for health information exchange.

CONSUMER HEALTHCARE WEBSITE (§ 20)

The bill requires the Healthcare Advocate's Office, within available appropriations, to create and maintain a website for consumer health care information. At a minimum, the website must contain (1) information about wellness programs, such as disease prevention and health promotion, available in various regions; (2) hospital quality and experience data; and (3) a link to the Insurance Department's managed

care consumer report card.

ON-LINE LICENSE RENEWAL (§ 13)

The bill requires DPH, by October 1, 2007, to implement a secure, on-line license renewal system for physicians; dentists; and registered, advance practice registered, and licensed practical nurses. The system must provide for electronic funds transfer or credit card payment. It permits DPH to charge up to \$5 for on-line payments.

SCHOOL-BASED HEALTH CENTERS (§§ 22-24)

The bill appropriates \$2.5 million in FY 08 for DPH to fund expansion and operating costs of school-based health centers (SBHCs) in priority school districts and federally designated health professional shortage or medically underserved areas or those designated as having medically underserved populations. It makes permanent the ad hoc committee established in 2006 to advise DPH on SBHCs. It requires the committee to meet at least quarterly and annually report recommendations to the Public Health and Education committees for statutory and regulatory changes to improve health care access through SBHCs.

The bill requires any SBHC constructed on or after October 1, 2007 that is located in, or attached to, a school building, to have an entrance separate from the school.

COMMUNITY HEALTH CENTERS (§§ 25 & 26)

The bill appropriates to DPH in FY 08 (1) \$2 million for infrastructure grants to community-based health centers, including health information technology and (2) \$500,000 for grants to these centers to transport patients to medical appointments. In making the latter grants, DPH must give priority to Federally Qualified Health Centers in areas with limited public transportation options.

BACKGROUND

Interpreter Services in Medicaid

The federal Civil Rights Act prohibits discrimination based on race,

color, or national origin. The courts and the U.S. Department of Health and Human Services have applied this law to the protection of national origin minorities who do not speak English well. The Office of Civil Rights has issued guidance on this law that essentially says health care providers caring for Medicaid clients must take reasonable steps to ensure meaningful access to care.

Special Disregard for Medically Needy

Federal Medicaid regulations allow states to establish separate income disregards for subgroups of their medically needy populations (e.g., aged, blind, and disabled). In Connecticut, this would be added to the existing unearned income disregard (currently \$227 per month), and have the effect of raising the income limit.

Personal Service Agreements (PSA)

In general, whenever a state agency wishes to hire a person, firm, or corporation to provide services on a contractual basis, a PSA must be executed, which defines the services the contractor must perform. For PSAs costing up to \$20,000, the contract should, but does not have to, be competitively bid. PSAs costing more than \$20,000 must be competitively bid, unless the agency purchasing the services (1) determines that a sole source is necessary, (2) applies to the Office of Policy and Management secretary for a waiver, and (3) the secretary grants it. The secretary must approve any PSA costing more than \$50,000, regardless of whether a waiver is requested (CGS § 4-212, et. seq.).

Section 125 Plans

The IRS Code (§ 125) permits employers to offer their employees a choice between cash salary and a variety of qualified, nontaxable benefits. Payments for a qualified benefit, which includes health care, vision and dental care, and group term-life and disability insurance, are excludable from an employee's gross income.

Electronic Health Information Exchange

eHealth Connecticut is a nonprofit corporation whose goal is to

create a secure, statewide system that enables the electronic exchange of health information among health care providers and payers. Its board comprises representatives of physicians, other health care providers, insurers, academics, and state agencies.

Related Bills

Several committees have favorably reported bills broadly addressing health care access that contain provisions similar to those in sSB 1. They are:

Bill Number	File Number	Committee
sSB 3	345	Human Services
sSB 70	106	Insurance
sSB 1127		Human Services
sSB 1371	233	Insurance
sHB 6158	6158	Children
sHB 6652	7314	Insurance
sHB 7314	264	Labor
sHB 7375	296	Human Services

In addition several other bills treat single issues that are part of SB 1.

1. sHB 6976, reported favorably by the Public Health and Human Services committees, requires DPH and the Office of Policy and Management to develop a five-year strategic plan for a statewide chronic disease management system.
2. sHB 7111 (file 370) requires DPH to establish, by July 1, 2008, a secure on-line license renewal system for physicians, surgeons, dentists, and nurses.

3. sHB 7366, favorably reported by the Public Health Committee, and sHB 6515, favorably reported by the Children’s and Public Health committees, appropriates funds for school- and community-based health centers. sHB 7366 also extends the life of the ad hoc SBHC committee.
4. sHB 6839, favorably reported by the Public Health Committee, establishes a Health Information Technology Office in DPH and requires it to develop a plan to establish a statewide health information exchange.
5. sHB 7069, favorably reported by the Public Health Committee, requires DSS to adopt a dental provider fee schedule like the one in sSB 1, but limited to pediatric services.
6. sSB 1181, reported favorably by the GAE committee, changes the PSA reporting requirements.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute

Yea 23 Nay 5 (03/26/2007)