



Senate

General Assembly

File No. 685

January Session, 2007

Senate Bill No. 1127

Senate, May 2, 2007

The Committee on Appropriations reported through SEN. HARP of the 10th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT CONCERNING THE CHARTER OAK HEALTH PLAN AND HEALTH CARE ACCESS.

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

1 Section 1. (NEW) (*Effective July 1, 2007*) (a) There is established the
2 Charter Oak Health Plan for the purpose of providing access to health
3 insurance coverage for state residents who have been uninsured for at
4 least six months and who are ineligible for other publicly funded
5 health insurance plans. The Commissioner of Social Services may enter
6 into contracts for the provision of comprehensive health care for such
7 uninsured state residents. The commissioner shall conduct outreach to
8 facilitate enrollment in the plan.

9 (b) The commissioner shall impose cost-sharing requirements in
10 connection with services provided under the Charter Oak Health Plan.
11 Such requirements may include, but not be limited to: (1) A monthly
12 premium; (2) an annual deductible not to exceed one thousand dollars;
13 (3) a coinsurance payment not to exceed twenty per cent after the
14 deductible amount is met; (4) tiered copayments for prescription drugs

15 determined by whether the drug is generic or brand name, formulary
16 or nonformulary and whether purchased through mail order; (5) no fee
17 for emergency visits to hospital emergency rooms; (6) a copayment not
18 to exceed one hundred fifty dollars for nonemergency visits to hospital
19 emergency rooms; and (7) a lifetime benefit not to exceed one million
20 dollars.

21 (c) The Commissioner of Social Services shall provide premium
22 assistance to eligible state residents whose gross annual income does
23 not exceed three hundred per cent of the federal poverty level. Such
24 premium assistance shall be limited to: (1) One hundred seventy-five
25 dollars per month for individuals whose gross annual income is below
26 one hundred fifty per cent of the federal poverty level; (2) one hundred
27 fifty dollars per month for individuals whose gross annual income is at
28 or above one hundred fifty per cent of the federal poverty level but not
29 more than one hundred eighty-five per cent of the federal poverty
30 level; (3) seventy-five dollars per month for individuals whose gross
31 annual income is above one hundred eighty-five per cent of the federal
32 poverty level but not more than two hundred thirty-five per cent of the
33 federal poverty level; and (4) fifty dollars per month for individuals
34 whose gross annual income is above two hundred thirty-five per cent
35 of the federal poverty level but not more than three hundred per cent
36 of the federal poverty level. Individuals insured under the Charter Oak
37 Health Plan shall pay their share of payment for coverage in the plan
38 directly to the insurer.

39 (d) The Commissioner of Social Services shall determine minimum
40 requirements on the amount, duration and scope of benefits under the
41 Charter Oak Health Plan, except that there shall be no preexisting
42 condition exclusion. Each participating insurer shall provide an
43 internal grievance process by which an insured may request and be
44 provided a review of a denial of coverage under the plan.

45 (e) The Commissioner of Social Services may contract with the
46 following entities for the purposes of this section: (1) A health care
47 center subject to the provisions of chapter 698a of the general statutes;

48 (2) a consortium of federally qualified health centers and other
49 community-based providers of health services which are funded by
50 the state; or (3) other consortia of providers of health care services
51 established for the purposes of this section. Providers of
52 comprehensive health care services as described in subdivisions (2)
53 and (3) of this subsection shall not be subject to the provisions of
54 chapter 698a of the general statutes. Any such provider shall be
55 certified by the commissioner to participate in the Charter Oak Health
56 Plan in accordance with criteria established by the commissioner,
57 including, but not limited to, minimum reserve fund requirements.

58 (f) The Commissioner of Social Services shall seek proposals from
59 entities described in subsection (e) of this section based on the cost
60 sharing and benefits described in subsections (b) and (c) of this section.
61 The commissioner may approve an alternative plan in order to make
62 coverage options available to those eligible to be insured under the
63 plan.

64 (g) The Commissioner of Social Services, pursuant to section 17b-10
65 of the general statutes, may implement policies and procedures to
66 administer the provisions of this section while in the process of
67 adopting such policies and procedures as regulation, provided the
68 commissioner prints notice of the intent to adopt the regulation in the
69 Connecticut Law Journal not later than twenty days after the date of
70 implementation. Such policies shall be valid until the time final
71 regulations are adopted and may include: (1) Exceptions to the
72 requirement that a resident be uninsured for at least six months to be
73 eligible for the Charter Oak Health Plan; and (2) requirements for open
74 enrollment and limitations on the ability of enrollees to change plans
75 between such open enrollment periods.

76 Sec. 2. Section 17b-296 of the general statutes is amended by adding
77 subsection (e) as follows (*Effective from passage*):

78 (NEW) (e) All contracts between the department and a managed
79 care organization to provide services under the HUSKY Plan, Part A,
80 the HUSKY Plan, Part B, or both, or the Charter Oak Health Plan,

81 pursuant to section 1 of this act, and all documents maintained by a
82 managed care organization related to the performance of its contracts
83 with the department, including, but not limited to, contracts and
84 agreements with providers and subcontractors, documents concerning
85 rates paid to providers and subcontractors, and documents concerning
86 operational standards, shall be deemed public records or files as
87 defined in section 1-200 and shall be subject to disclosure in
88 accordance with chapter 14.

89 Sec. 3. Section 1-218 of the general statutes is repealed and the
90 following is substituted in lieu thereof (*Effective from passage*):

91 Each contract in excess of two million five hundred thousand
92 dollars between a public agency and a person for the performance of a
93 governmental function shall (1) provide that the public agency is
94 entitled to receive a copy of records and files related to the
95 performance of the governmental function, and (2) indicate that such
96 records and files are subject to the Freedom of Information Act and
97 may be disclosed by the public agency pursuant to the Freedom of
98 Information Act. Any contract between the Department of Social
99 Services and a managed care organization to provide services under
100 the HUSKY Plan, Part A, the HUSKY Plan, Part B, or both, or the
101 Charter Oak Health Plan pursuant to section 1 of this act, irrespective
102 of whether such contract is in excess of two million five hundred
103 thousand dollars, shall be subject to the provisions of this section. No
104 request to inspect or copy such records or files shall be valid unless the
105 request is made to the public agency in accordance with the Freedom
106 of Information Act. Any complaint by a person who is denied the right
107 to inspect or copy such records or files shall be brought to the Freedom
108 of Information Commission in accordance with the provisions of
109 sections 1-205 and 1-206.

110 Sec. 4. Subdivision (11) of section 1-200 of the general statutes is
111 repealed and the following is substituted in lieu thereof (*Effective from*
112 *passage*):

113 (11) "Governmental function" means the administration or

114 management of a program of a public agency, which program has
115 been authorized by law to be administered or managed by a person,
116 where (A) the person receives funding from the public agency for
117 administering or managing the program, (B) the public agency is
118 involved in or regulates to a significant extent such person's
119 administration or management of the program, whether or not such
120 involvement or regulation is direct, pervasive, continuous or day-to-
121 day, and (C) the person participates in the formulation of
122 governmental policies or decisions in connection with the
123 administration or management of the program and such policies or
124 decisions bind the public agency. "Governmental function" includes
125 the provision of services by a managed care organization under the
126 HUSKY Plan, Part A, the HUSKY Plan, Part B, or both, or the Charter
127 Oak Health Plan, pursuant to section 1 of this act. "Governmental
128 function" [shall] does not include the mere provision of goods or
129 services to a public agency without the delegated responsibility to
130 administer or manage a program of a public agency.

131 Sec. 5. (*Effective from passage*) (a) There is established a task force to
132 study and make recommendations to increase provider participation
133 in the HUSKY Plan, Part A, the HUSKY Plan, Part B, or both, as
134 defined in section 17a-290 of the general statutes.

135 (b) The task force shall consist of the following members or their
136 designees: (1) The Commissioners of Social Services, Public Health,
137 Children and Families, Mental Health and Addiction Services, and
138 Health Care Access; (2) the chairperson of the Managed Care Council
139 established pursuant to section 17b-28 of the general statutes; (3) the
140 chairpersons and ranking members of the joint standing committees of
141 the General Assembly having cognizance of matters relating to human
142 services and public health; and (4) ten appointed by the Governor, (A)
143 one of whom shall be a representative from a managed care
144 organization; (B) seven of whom shall be representatives from
145 organizations providing health care services including, but not limited
146 to, hospitals, clinics, dental providers, physicians and nurses; and (C)
147 two of whom shall be consumer representatives.

148 (c) The Commissioner of Social Services shall serve as chairperson of
149 the task force and shall convene the initial meeting of the task force not
150 later than ninety days after the effective date of this section.

151 (d) The task force shall identify and analyze strategies to increase
152 provider participation in the HUSKY Plan and explore approaches to
153 increase provider participation, including, but not limited to, medical
154 malpractice coverage issues, alternative reimbursement strategies,
155 member lock-in policies and procedures, geographic issues, provider
156 cultural diversity, administrative simplification, capital investments
157 and recommended policy, regulatory or statutory changes.

158 (e) The task force shall report its findings and recommendations, in
159 accordance with section 11-4a of the general statutes, to the Governor
160 and the joint standing committees of the General Assembly having
161 cognizance of matters relating to human services and public health not
162 later than January 1, 2008. The task force shall terminate upon
163 submission of the report.

164 Sec. 6. (NEW) (*Effective July 1, 2007*) Each local or regional board of
165 education shall require each pupil enrolled in the schools under its
166 jurisdiction to annually report whether the pupil has health insurance.
167 The Commissioner of Social Services, or the commissioner's designee,
168 shall provide information to each local or regional board of education
169 on state-sponsored health insurance programs for children, including
170 application assistance for such programs. Each local or regional board
171 of education shall provide such information to the pupil's parent or
172 guardian, including application assistance for such programs.

173 Sec. 7. (*Effective July 1, 2007*) (a) The Commissioner of Health Care
174 Access shall convene an electronic health information technology task
175 force to develop and provide recommendations to the Governor on the
176 impact of electronic health information exchange.

177 (b) The task force shall be comprised of representatives from the
178 public and private sectors and be selected by the Commissioner of
179 Health Care Access. In appointing members to the task force, the

180 commissioner shall consider the representative interests of (1)
181 consumers; (2) providers including clinicians, pharmacists, health
182 plans, hospitals, federally qualified health centers, clinics, laboratories,
183 pharmacies and professional societies or organizations; (3) public
184 health entities; (4) academia; (5) employers; (6) health information
185 exchange organizations; (7) state agencies including the Departments
186 of Social Services, Public Health, Mental Retardation, Mental Health
187 and Addiction Services, Children and Families, Veterans' Affairs,
188 Information Technology, Consumer Protection, the Insurance
189 Department, The University of Connecticut Health Center, the Office
190 of Policy and Management and the Office of the State Comptroller; and
191 (8) municipalities. The Commissioner of Health Care Access shall serve
192 as the chairperson of the task force.

193 (c) The task force shall: (1) Research and examine the impact of the
194 electronic use of health information to improve the quality and
195 efficiency of health information exchange; (2) inventory the various
196 public and private health information technology initiatives currently
197 underway in Connecticut, including efforts regarding personal health
198 records, electronic health records and health information exchange; (3)
199 identify the appropriate role of state government in the development,
200 use and regulation of health information technology and define the
201 goals and values of health information technology for the purposes of
202 state policy and planning; (4) assess the impact of health information
203 on the state's roles as payor, provider, purchaser, regulator and
204 employer and recommend statutory, regulatory and policy changes
205 including changes required to address privacy, confidentiality and
206 public safety; (5) develop an overall state health information
207 technology policy; (6) develop options for advancing the
208 implementation of health information technology through the state's
209 roles as payor, provider, purchaser, regulator and employer and
210 identify opportunities and strategies for public and private
211 collaboration; and (7) develop policy options for advancing the
212 implementation of health information technology including projected
213 costs and sources of funding.

214 (d) Not later than September 1, 2008, the Commissioner of Health
215 Care Access shall report to the Governor, in accordance with section
216 11-4a of the general statutes, on the findings and recommendations of
217 the task force. The electronic health information technology task force
218 shall terminate upon the submission of the report.

219 Sec. 8. Subsection (e) of section 17b-292 of the general statutes is
220 repealed and the following is substituted in lieu thereof (*Effective July*
221 *1, 2007*):

222 (e) A newborn child who otherwise meets the eligibility criteria for
223 the HUSKY Plan, Part B shall be eligible for benefits retroactive to his
224 date of birth, provided an application is filed on behalf of the child
225 [within] not later than thirty days [of] after such date. Any uninsured
226 child born in a hospital in this state or in an eligible border state
227 hospital shall be enrolled by an expedited process in the HUSKY Plan,
228 Part B provided (1) the child's family resides in this state, and (2) a
229 parent of such child authorizes enrollment in the program. The
230 commissioner shall pay any premium cost such family would
231 otherwise incur for the first two months of coverage to the managed
232 care organization selected by the family to provide coverage for such
233 child.

234 Sec. 9. Section 17b-277 of the general statutes is repealed and the
235 following is substituted in lieu thereof (*Effective July 1, 2007*):

236 (a) The Commissioner of Social Services shall provide, in accordance
237 with federal law and regulations, medical assistance under the
238 Medicaid program to needy pregnant women and children up to one
239 year of age whose families have an income up to one hundred eighty-
240 five per cent of the federal poverty level.

241 (b) The commissioner shall expedite eligibility for appropriate
242 pregnant women applicants for the Medicaid program. The process for
243 making expedited eligibility determinations concerning needy
244 pregnant women shall ensure that emergency applications for
245 assistance, as determined by the commissioner, shall be processed no

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

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 08 \$	FY 09 \$
Various State Agencies	GF - Cost	Significant	Significant

Municipal Impact: See below

Explanation

Section 1 of this bill establishes the Charter Oak Health Plan under the Department of Social Services (DSS), which will offer subsidized health insurance for uninsured adults in Connecticut. The overall costs of this plan will be dependent upon the final health care package design and the cost sharing requirements, both of which are to be developed by DSS. The cost will also be dependent upon enrollment and private insurance participation. These factors are not known at this time. The Governor’s recommended FY08-09 biennial budget included \$18.9 million in FY08 and \$36.1 million in FY09 to design and implement this plan. sHB 7077 (the Appropriations Act, as approved by the Appropriations Committee) includes \$2 million in FY08 to begin the design of the plan and to issue a request for proposals from commercial insurance carriers. sHB 7077 does not anticipate implementation of this plan during the upcoming biennium.

Sections 2 through 4 of the bill make managed care contracts subject to Freedom of Information policies. This change is not expected to have a direct fiscal impact on the state.

Section 5 of the bill establishes a task force to study and make recommendations to increase provider participation in the HUSKY Plans. The task force must report its findings and recommendations to the General Assembly by January 1, 2008. The state agencies

involved with the task force can participate within normal budgetary resources.

Section 6 of the bill stipulates that each local or regional board of education require each pupil to annually report whether the pupil has health insurance. This requirement will result in a cost of approximately \$50,000 annually for additional forms. The bill is not clear whether the cost of these forms is to be borne by the school boards, the State Department of Education or DSS.

It is expected that through enhanced identification of uninsured children and subsequent referral to the HUSKY programs, DSS will realize increased enrolment in these programs. sHB 7077 assumes that an additional 3,300 children will be enrolled under this initiative, at a cost of \$5.4 million in FY08 and \$8.4 million in FY09.

Section 7 establishes the Electronic Health Information Technology Task Force. sHB 7077 includes \$500,000 for FY 08 to allow the Office of Health Care Access to assist the Task Force. It is expected that representatives of various state agencies will serve as Task Force members within their respective agency's normally budgeted resources.

Sections 8 and 9 require expedited HUSKY B enrollment of uninsured newborns and requires DSS to pay any premium costs for the first two months of coverage. There are approximately 90 uninsured births monthly in Connecticut. Enrolling these children in HUSKY B and paying full premiums for the first two months is expected to cost \$2,700,000 in FY08 and \$4,600,000 in FY09. sHB 7077 contains \$3.9 million in FY08 and \$8.2 million in FY09 to pay full premiums for six months after birth. These costs would be 65% reimbursable under the federal SCHIP program.

The Out Years

The annualized ongoing fiscal impact identified above would

continue into the future subject to inflation.

OLR Bill Analysis**SB 1127*****AN ACT CONCERNING THE CHARTER OAK HEALTH PLAN AND HEALTH CARE ACCESS.*****SUMMARY:**

This bill attempts to reduce the number of uninsured state residents in several ways. It:

1. establishes a Charter Oak Health Plan for residents who have been uninsured for at least six months and are ineligible for publicly funded health care,
2. provides premium assistance for the plan for residents with incomes below 300% of the federal poverty level (FPL) (currently \$51,510 annually for a family of three),
3. provides for automatic enrollment of newborns in HUSKY, and
4. requires local school boards to report the number of students who lack insurance.

The bill also creates two task forces, one addressing the shortage of providers in HUSKY and the other the use of electronic health information technology.

The bill makes the performance of HUSKY and Charter Oak Health Plan managed care contracts a governmental function under the Freedom of Information Act (FOIA), regardless of the value of the contract.

EFFECTIVE DATE: July 1, 2007 except for the provisions concerning the FOIA and task forces, which are effective upon passage.

CHARTER OAK HEALTH PLAN

Contracts for Health Care

In establishing the plan, the bill authorizes the Department of Social Services (DSS) commissioner to enter into contracts to provide comprehensive health care for the state's uninsured residents. It requires the commissioner to conduct outreach to facilitate enrollment in the plan.

Cost Sharing

The bill requires the DSS commissioner to impose cost sharing for plan participants. This may include:

1. monthly premiums;
2. a maximum \$1,000 annual deductible;
3. coinsurance of no more than 20%, once the deductible is met;
4. tiered co-payments for prescription drugs, depending on whether the drug is on a formulary, is a brand name, or whether it is mail-ordered;
5. no fees for emergency visits to hospital emergency rooms and a maximum \$150 fee for nonemergency visits; and
6. a \$1 million lifetime benefit limit.

Premium Assistance

Residents purchasing the insurance pay premiums directly to the insurer and qualify for premium assistance if their income is less than 300% of the FPL. The assistance amounts are shown below.

<i>Income Level</i>	<i>Monthly Premium Assistance</i>
Below 150% of FPL	\$175
150% to 185% of FPL	\$150

185% to 235% of FPL	\$75
235% to 300% of FPL	\$50

Coverage

The bill requires the DSS commissioner to determine minimum requirements for the plan's amount, duration, and scope of benefits, which cannot include a pre-existing condition exclusion. Each participating insurer must provide an internal grievance process through which an insured person can request and receive a review of any coverage denial.

Allowable Plans

The bill authorizes DSS to contract with any of the following entities to provide coverage:

1. managed care organizations,
2. a consortium of federally qualified health centers and other state-funded, community-based health care providers; and
3. other health care provider consortia established to serve plan participants.

The bill specifies that the above consortia are not subject to the laws governing MCOs, hospital service corporations, and medical service corporations. These laws include annual financial filings with the Department of Insurance (DOI), DOI rate approval, and investment limitations.

Before these providers may participate in the plan, the DSS commissioner must certify them according to criteria he or she establishes, which must include minimum reserve fund requirements.

The bill requires the commissioner to seek proposals from the entities based on the cost-sharing and benefits (presumably those that the entities offer). It allows the commissioner to approve an alternative

plan to make coverage options available to eligible residents.

Regulations; Exception to Six-Month Crowd Out and Enrollment Restrictions

The bill permits the DSS commissioner to implement policies and procedures for administering the plan while in the process of adopting them as regulations, if notice of intent to adopt the regulations is published in the *Connecticut Law Journal* within 20 days of implementation. The policies and procedures are valid until the regulations are adopted.

The bill allows the policies and regulations to include an exception to the six-month period of noninsurance and requirements for open enrollment periods, and limiting enrollees' ability to change plans between these periods.

HUSKY ENROLLMENT OF NEWBORNS

The bill requires that any uninsured child born in a Connecticut hospital or "eligible border hospital" to be enrolled in HUSKY B on an "expedited" basis when (1) the child's family lives in the state and (2) a parent of the child authorizes the enrollment. It requires the DSS commissioner to pay the MCO that the family chooses the first two months of premiums that the family would otherwise have to pay.

Likewise, the bill requires HUSKY A eligibility to be granted "presumptively" to uninsured newborns born in these hospitals if the same two conditions are met.

SCHOOL DISTRICT REPORTING OF STUDENT INSURANCE RATES

The bill requires local or regional school boards to require all students in their jurisdiction to report whether they have health insurance. The DSS commissioner, or his designee, must provide information to the boards on state-sponsored health insurance programs for children, including application assistance. The boards must provide this information, and application assistance, to the student's parent or guardian.

DISCLOSURE OF HUSKY AND CHARTER OAK PLAN RECORDS

The bill requires that certain language be included in contracts and related documents between DSS and managed care organizations serving individuals receiving HUSKY or Charter Oak Health Plan benefits. It specifies that these include (1) contracts and agreements with providers and subcontractors, (2) documents concerning rates paid to them, and (3) documents concerning operational standards. The requirement applies to contracts of any value.

The bill includes MCOs providing services to HUSKY or Charter Oak Health Plan beneficiaries in the definition of a governmental function. Thus, the contracts must (1) entitle DSS to copies of records and files related to the contract's performance and (2) indicate that the records and files are subject to disclosure under FOIA. Anyone denied access to the records or files must first file a complaint with the Freedom of Information Commission.

TASK FORCES***Increasing Provider Participation in HUSKY***

The 20-member task force consists of the following individuals or their designees:

1. the commissioners of DSS, public health, children and families, mental health and addiction services, and health care access;
2. the chairperson of the Medicaid Managed Care Council;
3. the chairpersons and ranking members of the Human Services and Public Health committees; and
4. 10 members the governor appoints.

One of the governor's appointments must be an MCO representative; seven must represent health care service provider organizations, including hospitals, clinics, dental providers, physicians, and nurses; and two are consumer representatives.

The DSS commissioner chairs the task force and must convene the

first meeting within 90 days of the bill's passage.

The task force must identify and analyze strategies to increase provider participation in HUSKY; explore approaches to increasing provider participation; and recommend policy, regulatory, or statutory changes. It must specifically examine:

1. medical malpractice coverage issues,
2. alternative reimbursement strategies,
3. member lock-in policies and procedures,
4. geographic issues,
5. provider cultural diversity,
6. administrative simplification, and
7. capital investments.

The task force must report its finding and recommendations to the Human Services and Public Health committees by January 1, 2008, at which point the task force terminates.

Electronic Health Information Technology Task Force

The bill requires the Office of Health Care Access (OHCA) commissioner to convene and chair this task force, which must develop and provide recommendations to the governor on the effect of electronic health information exchanges.

The OHCA commissioner selects the task force members, who must represent the public and private sectors. In choosing the members, the commissioner must look for individuals to represent the interests of consumers, health care providers and organizations, public health entities, academia, employers, health information exchange organizations, state agencies, and municipalities.

The task force must:

1. research and examine the impact of using electronic information to improve the quality and efficiency of health information exchange;
2. inventory the health information technology initiatives currently underway in the state;
3. identify state government's appropriate role in developing, using, and regulating the technology;
4. define the goals and values of the technology for state policy and planning purposes;
5. assess the information's impact on the state's role as a health care regulator, purchaser, provider, and payor, and employer, and recommend policy and legal changes necessary to address privacy, confidentiality, and public safety;
6. develop options for advancing the technology's implementation through the state's various roles, including projected costs and funding sources, and identify strategies for public and private collaboration; and
7. develop an overall state health information technology policy.

The OHCA commissioner must report to the governor on the task force's findings and recommendations by September 1, 2008, at which time the task force terminates.

BACKGROUND

HUSKY

HUSKY A (Medicaid) offers subsidized managed health care coverage to children in families with income up to 185% of the FPL, and to their caretaker relatives who have income up to 150% of the FPL. Enrollees do not pay cost-sharing.

HUSKY B offers similar health care coverage to children in families with incomes between 185% and 300% of the FPL, with monthly

premiums required from families with incomes over 235% of the FPL. Children whose family income is over 300% of FPL can buy unsubsidized coverage by paying the MCO the full premium amount (about \$200 per child per month). Participants pay co-payments for certain services.

Presumptive Eligibility in HUSKY A

Under presumptive eligibility, states can grant Medicaid (HUSKY A) to children almost immediately, verifying the information supplied on the application after eligibility is granted. DSS maintains contracts with qualified entities, which can include hospitals, to do these eligibility determinations.

Expedited Eligibility in HUSKY A

Pregnant women with income up to 185% of the FPL are eligible for Medicaid on an expedited basis. In emergencies, this requires DSS to process applications no later than 24 hours after receiving all required information from the applicant; for nonemergency applicants, DSS can take up to five days.

Related Bills

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

<i>Bill Number</i>	<i>File #</i>	<i>Committee</i>
sSB 1	472	Public Health
sSB 3	345	Human Services
sSB 70	106	Insurance
sSB 1371	233	Insurance
sHB 6158	246	Children
sHB 6652	219	Insurance

sHB 7314	264	Labor
sHB 7375	296	Human Services

sHB 7322 (File 380) and sSB 1425 (File 357) contain similar provisions concerning FOIA. sSB 1290 (File 446) extends the definition of performing a governmental function.

sSB1 (File 472) designates eHealth Connecticut as the lead health information exchange organization for the state.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Change of Reference

Yea 19 Nay 0 (03/22/2007)

Appropriations Committee

Joint Favorable

Yea 48 Nay 0 (04/19/2007)