



General Assembly

January Session, 2007

Raised Bill No. 7278

LCO No. 4527

04527 _____ HS_

Referred to Committee on Human Services

Introduced by:
(HS)

AN ACT CONCERNING IMPROVED ACCESS TO HEALTH INSURANCE.

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

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 Section 17b-261 of the general statutes is repealed and the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

3 (a) Medical assistance shall be provided for any otherwise eligible
4 person whose income, including any available support from legally
5 liable relatives and the income of the person's spouse or dependent
6 child, is not more than one hundred forty-three per cent, pending
7 approval of a federal waiver applied for pursuant to subsection (d) of
8 this section, of the benefit amount paid to a person with no income
9 under the temporary family assistance program in the appropriate
10 region of residence and if such person is an institutionalized
11 individual as defined in Section 1917(c) of the Social Security Act, 42
12 USC 1396p(c), and has not made an assignment or transfer or other
13 disposition of property for less than fair market value for the purpose
14 of establishing eligibility for benefits or assistance under this section.
15 Any such disposition shall be treated in accordance with Section
16 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of

17 property made on behalf of an applicant or recipient or the spouse of
18 an applicant or recipient by a guardian, conservator, person
19 authorized to make such disposition pursuant to a power of attorney
20 or other person so authorized by law shall be attributed to such
21 applicant, recipient or spouse. A disposition of property ordered by a
22 court shall be evaluated in accordance with the standards applied to
23 any other such disposition for the purpose of determining eligibility.
24 The commissioner shall establish the standards for eligibility for
25 medical assistance at one hundred forty-three per cent of the benefit
26 amount paid to a family unit of equal size with no income under the
27 temporary family assistance program in the appropriate region of
28 residence, pending federal approval, except that the medical assistance
29 program shall provide coverage to persons under the age of nineteen
30 up to one hundred eighty-five per cent of the federal poverty level
31 without an asset limit. Said medical assistance program shall also
32 provide coverage to persons under the age of nineteen and their
33 parents and needy caretaker relatives who qualify for coverage under
34 Section 1931 of the Social Security Act with family income up to one
35 hundred fifty per cent of the federal poverty level without an asset
36 limit, upon the request of such a person or upon a redetermination of
37 eligibility. Such levels shall be based on the regional differences in
38 such benefit amount, if applicable, unless such levels based on regional
39 differences are not in conformance with federal law. Any income in
40 excess of the applicable amounts shall be applied as may be required
41 by said federal law, and assistance shall be granted for the balance of
42 the cost of authorized medical assistance. All contracts entered into on
43 and after July 1, 1997, pursuant to this section shall include provisions
44 for collaboration of managed care organizations with the Nurturing
45 Families Network established pursuant to section 17a-56. The
46 Commissioner of Social Services shall provide applicants for assistance
47 under this section, at the time of application, with a written statement
48 advising them of (1) the effect of an assignment or transfer or other
49 disposition of property on eligibility for benefits or assistance, and (2)
50 the availability of, and eligibility for, services provided by the

51 Nurturing Families Network established pursuant to section 17a-56.

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

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

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

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

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

82 Security Act due to income from employment by one of its members
83 who is a caretaker relative or due to receipt of child support income. A
84 family receiving extended benefits on July 1, [2005] 2007, shall receive
85 the balance of such extended benefits, provided no such family shall
86 receive more than twelve additional months of such benefits.

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

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

115 later than twenty days after implementation. Policies and procedures
116 implemented pursuant to this subsection shall be valid until the time
117 final regulations are adopted.]

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

126 [(j)] (i) The Commissioner of Social Services shall provide Early and
127 Periodic Screening, Diagnostic and Treatment program services, as
128 required and defined as of December 31, 2005, by 42 USC 1396a(a)(43),
129 42 USC 1396d(r) and 42 USC 1396d(a)(4)(B) and applicable federal
130 regulations, to all persons who are under the age of twenty-one and
131 otherwise eligible for medical assistance under this section.

132 Sec. 2. Section 17b-292 of the general statutes is repealed and the
133 following is substituted in lieu thereof (*Effective July 1, 2007*):

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

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

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

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

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

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

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

174 [(g)] (h) The commissioner shall enter into a contract with an entity
175 to be a single point of entry servicer for applicants and enrollees under
176 the HUSKY Plan, Part A and Part B. The servicer shall jointly market

177 both Part A and Part B together as the HUSKY Plan. Such servicer shall
178 develop and implement public information and outreach activities
179 with community programs. Such servicer shall electronically transmit
180 data with respect to enrollment and disenrollment in the HUSKY Plan,
181 Part B to the commissioner.

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

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

208 [(j)] (k) Not more than twelve months after the determination of

209 eligibility for benefits under the HUSKY Plan, Part A and Part B and
210 annually thereafter, the commissioner or the servicer, as the case may
211 be, shall determine if the child continues to be eligible for the plan. The
212 commissioner or the servicer shall mail an application form to each
213 participant in the plan for the purposes of obtaining information to
214 make a determination on eligibility. To the extent permitted by federal
215 law, in determining eligibility for benefits under the HUSKY Plan, Part
216 A or Part B with respect to family income, the commissioner or the
217 servicer shall rely upon information provided in such form by the
218 participant unless the commissioner or the servicer has reason to
219 believe that such information is inaccurate or incomplete. The
220 Department of Social Services shall annually review a random sample
221 of cases to confirm that, based on the statistical sample, relying on such
222 information is not resulting in ineligible clients receiving benefits
223 under HUSKY Plan Part A or Part B. The determination of eligibility
224 shall be coordinated with health plan open enrollment periods.

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

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

236 Sec. 3. Section 17b-261c of the general statutes is repealed. (*Effective*
237 *July 1, 2007*)

<p>This act shall take effect as follows and shall amend the following sections:</p>
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Section 1	<i>July 1, 2007</i>	17b-261
Sec. 2	<i>July 1, 2007</i>	17b-292
Sec. 3	<i>July 1, 2007</i>	Repealer section

Statement of Purpose:

To improve access to health insurance coverage for Connecticut residents and reduce the number of uninsured persons.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]