



General Assembly

January Session, 2007

Bill No. 1484

LCO No. 9262

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Referred to Committee on No Committee

Introduced by:

SEN. WILLIAMS, 29th Dist.

REP. AMANN, 118th Dist.

SEN. LOONEY, 11th Dist.

REP. DONOVAN, 84th Dist.

***AN ACT CONCERNING THE HEALTHFIRST CONNECTICUT AND
HEALTHY KIDS INITIATIVES.***

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 Section 17b-28e of the general statutes is repealed and the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 Section 17b-192 of the general statutes is repealed and the
14 following is substituted in lieu thereof (*Effective July 1, 2007*):

15 (a) The Commissioner of Social Services shall implement a state
16 medical assistance component of the state-administered general
17 assistance program for persons ineligible for Medicaid. [Not later than
18 October 1, 2003, each] Eligibility criteria concerning income shall be the
19 same as the medically needy component of the Medicaid program,
20 except that earned monthly gross income of up to one hundred fifty
21 dollars shall be disregarded. Unearned income shall not be
22 disregarded. No person who has family assets exceeding one thousand
23 dollars shall be eligible. No person shall be eligible for assistance
24 under this section if such person made, during the three months prior
25 to the month of application, an assignment or transfer or other
26 disposition of property for less than fair market value. The number of
27 months of ineligibility due to such disposition shall be determined by
28 dividing the fair market value of such property, less any consideration
29 received in exchange for its disposition, by five hundred dollars. Such
30 period of ineligibility shall commence in the month in which the
31 person is otherwise eligible for benefits. Any assignment, transfer or
32 other disposition of property, on the part of the transferor, shall be
33 presumed to have been made for the purpose of establishing eligibility
34 for benefits or services unless such person provides convincing
35 evidence to establish that the transaction was exclusively for some
36 other purpose.

37 (b) Each person eligible for state-administered general assistance
38 shall be entitled to receive medical care through a federally qualified
39 health center or other primary care provider as determined by the
40 commissioner. The Commissioner of Social Services shall determine
41 appropriate service areas and shall, in the commissioner's discretion,
42 contract with community health centers, other similar clinics, and
43 other primary care providers, if necessary, to assure access to primary
44 care services for recipients who live farther than a reasonable distance
45 from a federally qualified health center. The commissioner shall assign

46 and enroll eligible persons in federally qualified health centers and
47 with any other providers contracted for the program because of access
48 needs. [Not later than October 1, 2003, each] Each person eligible for
49 state-administered general assistance shall be entitled to receive
50 hospital services. Medical services under the program shall be limited
51 to the services provided by a federally qualified health center, hospital,
52 or other provider contracted for the program at the commissioner's
53 discretion because of access needs. The commissioner shall ensure that
54 ancillary services and specialty services are provided by a federally
55 qualified health center, hospital, or other providers contracted for the
56 program at the commissioner's discretion. Ancillary services include,
57 but are not limited to, radiology, laboratory, and other diagnostic
58 services not available from a recipient's assigned primary-care
59 provider, and durable medical equipment. Specialty services are
60 services provided by a physician with a specialty that are not included
61 in ancillary services. In no event shall ancillary or specialty services
62 provided under the program exceed such services provided under the
63 state-administered general assistance program on July 1, 2003.
64 [Eligibility criteria concerning income shall be the same as the
65 medically needy component of the Medicaid program, except that
66 earned monthly gross income of up to one hundred fifty dollars shall
67 be disregarded. Unearned income shall not be disregarded. No person
68 who has family assets exceeding one thousand dollars shall be eligible.
69 No person eligible for Medicaid shall be eligible to receive medical
70 care through the state-administered general assistance program. No
71 person shall be eligible for assistance under this section if such person
72 made, during the three months prior to the month of application, an
73 assignment or transfer or other disposition of property for less than
74 fair market value. The number of months of ineligibility due to such
75 disposition shall be determined by dividing the fair market value of
76 such property, less any consideration received in exchange for its
77 disposition, by five hundred dollars. Such period of ineligibility shall
78 commence in the month in which the person is otherwise eligible for
79 benefits. Any assignment, transfer or other disposition of property, on

80 the part of the transferor, shall be presumed to have been made for the
81 purpose of establishing eligibility for benefits or services unless such
82 person provides convincing evidence to establish that the transaction
83 was exclusively for some other purpose.]

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

89 (c) [On and after October 1, 2003, pharmacy] Pharmacy services
90 shall be provided to recipients of state-administered general assistance
91 through the federally qualified health center to which they are
92 assigned or through a pharmacy with which the health center
93 contracts. [Prior to said date, pharmacy services shall be provided as
94 provided under the Medicaid program.] Recipients who are assigned
95 to a community health center or similar clinic or primary care provider
96 other than a federally qualified health center or to a federally qualified
97 health center that does not have a contract for pharmacy services shall
98 receive pharmacy services at pharmacies designated by the
99 commissioner. The Commissioner of Social Services or the managed
100 care organization or other entity performing administrative functions
101 for the program as permitted in subsection (d) of this section, shall
102 require prior authorization for coverage of drugs for the treatment of
103 erectile dysfunction. The commissioner or the managed care
104 organization or other entity performing administrative functions for
105 the program may limit or exclude coverage for drugs for the treatment
106 of erectile dysfunction for persons who have been convicted of a sexual
107 offense who are required to register with the Commissioner of Public
108 Safety pursuant to chapter 969.

109 (d) The Commissioner of Social Services shall contract with
110 federally qualified health centers or other primary care providers as
111 necessary to provide medical services to eligible state-administered

112 general assistance recipients pursuant to this section. The
113 commissioner shall, within available appropriations, make payments
114 to such centers based on their pro rata share of the cost of services
115 provided or the number of clients served, or both. The Commissioner
116 of Social Services shall, within available appropriations, make
117 payments to other providers based on a methodology determined by
118 the commissioner. The Commissioner of Social Services may reimburse
119 for extraordinary medical services, provided such services are
120 documented to the satisfaction of the commissioner. For purposes of
121 this section, the commissioner may contract with a managed care
122 organization or other entity to perform administrative functions,
123 including a grievance process for recipients to access review of a denial
124 of coverage for a specific medical service, and to operate the program
125 in whole or in part. Provisions of a contract for medical services
126 entered into by the commissioner pursuant to this section shall
127 supersede any inconsistent provision in the regulations of Connecticut
128 state agencies. A recipient who has exhausted the grievance process
129 established through such contract and wishes to seek further review of
130 the denial of coverage for a specific medical service may request a
131 hearing in accordance with the provisions of section 17b-60.

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

139 (f) The Commissioner of Social Services shall, within available
140 appropriations, make payments to hospitals for inpatient services
141 based on their pro rata share of the cost of services provided or the
142 number of clients served, or both. The Commissioner of Social Services
143 shall, within available appropriations, make payments for any
144 ancillary or specialty services provided to state-administered general

145 assistance recipients under this section based on a methodology
146 determined by the commissioner.

147 (g) On or before [March 1, 2004] January 1, 2008, the Commissioner
148 of Social Services shall seek a waiver of federal law [under the Health
149 Insurance Flexibility and Accountability demonstration initiative] for
150 the purpose of extending health insurance coverage under Medicaid to
151 persons [qualifying] with income not in excess of one hundred per cent
152 of the federal poverty level who otherwise qualify for medical
153 assistance under the state-administered general assistance program.
154 The provisions of section 17b-8 shall apply to this section.

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

162 Sec. 3. Section 17b-261 of the general statutes is repealed and the
163 following is substituted in lieu thereof (*Effective July 1, 2007*):

164 (a) Medical assistance shall be provided for any otherwise eligible
165 person whose income, including any available support from legally
166 liable relatives and the income of the person's spouse or dependent
167 child, is not more than one hundred forty-three per cent, pending
168 approval of a federal waiver applied for pursuant to subsection (d) of
169 this section, of the benefit amount paid to a person with no income
170 under the temporary family assistance program in the appropriate
171 region of residence and if such person is an institutionalized
172 individual as defined in Section 1917(c) of the Social Security Act, 42
173 USC 1396p(c), and has not made an assignment or transfer or other
174 disposition of property for less than fair market value for the purpose
175 of establishing eligibility for benefits or assistance under this section.
176 Any such disposition shall be treated in accordance with Section

177 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
178 property made on behalf of an applicant or recipient or the spouse of
179 an applicant or recipient by a guardian, conservator, person
180 authorized to make such disposition pursuant to a power of attorney
181 or other person so authorized by law shall be attributed to such
182 applicant, recipient or spouse. A disposition of property ordered by a
183 court shall be evaluated in accordance with the standards applied to
184 any other such disposition for the purpose of determining eligibility.
185 The commissioner shall establish the standards for eligibility for
186 medical assistance at one hundred forty-three per cent of the benefit
187 amount paid to a family unit of equal size with no income under the
188 temporary family assistance program in the appropriate region of
189 residence. [pending federal approval, except that the] Except as
190 provided in section 17b-277, as amended by this act, the medical
191 assistance program shall provide coverage to persons under the age of
192 nineteen [up to one hundred eighty-five per cent of the federal poverty
193 level without an asset limit. Said medical assistance program shall also
194 provide coverage to persons under the age of nineteen] and their
195 parents and needy caretaker relatives, who qualify for coverage under
196 Section 1931 of the Social Security Act, with family income up to one
197 hundred [fifty] eighty-five per cent of the federal poverty level without
198 an asset limit. [upon the request of such a person or upon a
199 redetermination of eligibility.] Such levels shall be based on the
200 regional differences in such benefit amount, if applicable, unless such
201 levels based on regional differences are not in conformance with
202 federal law. Any income in excess of the applicable amounts shall be
203 applied as may be required by said federal law, and assistance shall be
204 granted for the balance of the cost of authorized medical assistance. All
205 contracts entered into on and after July 1, 1997, pursuant to this section
206 shall include provisions for collaboration of managed care
207 organizations with the Nurturing Families Network established
208 pursuant to section 17a-56. The Commissioner of Social Services shall
209 provide applicants for assistance under this section, at the time of
210 application, with a written statement advising them of (1) the effect of

211 an assignment or transfer or other disposition of property on eligibility
212 for benefits or assistance, (2) the effect that having income that exceeds
213 the limits prescribed in this subsection will have with respect to
214 program eligibility, (3) the availability of HUSKY Plan, Part B health
215 insurance benefits for persons who are not eligible for assistance
216 pursuant to this subsection or who are subsequently determined
217 ineligible for assistance pursuant to this subsection, and [(2)] (4) the
218 availability of, and eligibility for, services provided by the Nurturing
219 Families Network established pursuant to section 17a-56.

220 (b) For the purposes of the Medicaid program, the Commissioner of
221 Social Services shall consider parental income and resources as
222 available to a child under eighteen years of age who is living with his
223 or her parents and is blind or disabled for purposes of the Medicaid
224 program, or to any other child under twenty-one years of age who is
225 living with his or her parents.

226 (c) For the purposes of determining eligibility for the Medicaid
227 program, an available asset is one that is actually available to the
228 applicant or one that the applicant has the legal right, authority or
229 power to obtain or to have applied for the applicant's general or
230 medical support. If the terms of a trust provide for the support of an
231 applicant, the refusal of a trustee to make a distribution from the trust
232 does not render the trust an unavailable asset. Notwithstanding the
233 provisions of this subsection, the availability of funds in a trust or
234 similar instrument funded in whole or in part by the applicant or the
235 applicant's spouse shall be determined pursuant to the Omnibus
236 Budget Reconciliation Act of 1993, 42 USC 1396p. The provisions of
237 this subsection shall not apply to special needs trust, as defined in 42
238 USC 1396p(d)(4)(A).

239 (d) The transfer of an asset in exchange for other valuable
240 consideration shall be allowable to the extent the value of the other
241 valuable consideration is equal to or greater than the value of the asset
242 transferred.

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

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

255 (g) An institutionalized spouse applying for Medicaid and having a
256 spouse living in the community shall be required, to the maximum
257 extent permitted by law, to divert income to such community spouse
258 in order to raise the community spouse's income to the level of the
259 minimum monthly needs allowance, as described in Section 1924 of
260 the Social Security Act. Such diversion of income shall occur before the
261 community spouse is allowed to retain assets in excess of the
262 community spouse protected amount described in Section 1924 of the
263 Social Security Act. The Commissioner of Social Services, pursuant to
264 section 17b-10, may implement the provisions of this subsection while
265 in the process of adopting regulations, provided the commissioner
266 prints notice of intent to adopt the regulations in the Connecticut Law
267 Journal within twenty days of adopting such policy. Such policy shall
268 be valid until the time final regulations are effective.

269 (h) The Commissioner of Social Services shall, to the extent
270 permitted by federal law, or, pursuant to an approved waiver of
271 federal law submitted by the commissioner, in accordance with the
272 provisions of section 17b-8, impose the following cost-sharing
273 requirements under the HUSKY Plan, on all parent and needy
274 caretaker relatives with incomes exceeding one hundred per cent of the

275 federal poverty level: (1) A twenty-five-dollar premium per month per
276 parent or needy caretaker relative; and (2) a copayment of one dollar
277 per visit for outpatient medical services delivered by an enrolled
278 Medicaid or HUSKY Plan provider. The commissioner may implement
279 policies and procedures necessary to administer the provisions of this
280 subsection while in the process of adopting such policies and
281 procedures as regulations, provided the commissioner publishes notice
282 of the intent to adopt regulations in the Connecticut Law Journal not
283 later than twenty days after implementation. Policies and procedures
284 implemented pursuant to this subsection shall be valid until the time
285 final regulations are adopted.

286 (i) Medical assistance shall be provided, in accordance with the
287 provisions of subsection (e) of section 17a-6, to any child under the
288 supervision of the Commissioner of Children and Families who is not
289 receiving Medicaid benefits, has not yet qualified for Medicaid benefits
290 or is otherwise ineligible for such benefits because of institutional
291 status. To the extent practicable, the Commissioner of Children and
292 Families shall apply for, or assist such child in qualifying for, the
293 Medicaid program.

294 (j) The Commissioner of Social Services shall provide Early and
295 Periodic Screening, Diagnostic and Treatment program services, as
296 required and defined as of December 31, 2005, by 42 USC 1396a(a)(43),
297 42 USC 1396d(r) and 42 USC 1396d(a)(4)(B) and applicable federal
298 regulations, to all persons who are under the age of twenty-one and
299 otherwise eligible for medical assistance under this section.

300 Sec. 4. Section 17b-277 of the general statutes is repealed and the
301 following is substituted in lieu thereof (*Effective July 1, 2007*):

302 (a) The Commissioner of Social Services shall provide, in accordance
303 with federal law and regulations, medical assistance under the
304 Medicaid program to needy pregnant women [and children up to one
305 year of age] whose families have an income [up to one hundred eighty-
306 five] not exceeding two hundred fifty per cent of the federal poverty

307 level.

308 (b) The commissioner shall expedite eligibility for appropriate
309 pregnant women applicants for the Medicaid program. The process for
310 making expedited eligibility determinations concerning needy
311 pregnant women shall ensure that emergency applications for
312 assistance, as determined by the commissioner, shall be processed no
313 later than twenty-four hours after receipt of all required information
314 from the applicant, and that nonemergency applications for assistance,
315 as determined by the commissioner, shall be processed no later than
316 five calendar days after the date of receipt of all required information
317 from the applicant.

318 (c) Presumptive eligibility for medical assistance shall be
319 implemented for any uninsured newborn child born in a hospital in
320 this state or a border state hospital, provided (1) the parent or
321 caretaker relative of such child resides in this state, and (2) the parent
322 or caretaker relative of such child authorizes enrollment in the
323 program.

324 ~~[(c)]~~ (d) The commissioner shall submit biannual reports to the
325 council, established pursuant to section 17b-28, on the department's
326 compliance with the administrative processing requirements set forth
327 in subsection (b) of this section.

328 Sec. 5. Section 17b-289 of the general statutes is repealed and the
329 following is substituted in lieu thereof (*Effective July 1, 2007*):

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

333 (b) Children, caretaker relatives and pregnant women receiving
334 assistance under section 17b-261 or 17b-277 shall be participants in the
335 HUSKY Plan, Part A and children receiving assistance under sections
336 17b-289 to 17b-303, inclusive, and section 16 of public act 97-1 of the

337 October 29 special session* shall be participants in the HUSKY Plan,
338 Part B. For purposes of marketing and outreach and enrollment of
339 persons eligible for assistance, both parts shall be known as the
340 HUSKY Plan.

341 Sec. 6. Section 17b-292 of the general statutes is repealed and the
342 following is substituted in lieu thereof (*Effective July 1, 2007*):

343 (a) A child who resides in a household with a family income which
344 exceeds one hundred eighty-five per cent of the federal poverty level
345 and does not exceed [three] four hundred per cent of the federal
346 poverty level may be eligible for subsidized benefits under the HUSKY
347 Plan, Part B.

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

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

354 (d) To the extent allowed under federal law, the commissioner shall
355 not pay for services or durable medical equipment under the HUSKY
356 Plan, Part B if the enrollee has other insurance coverage for the services
357 or such equipment.

358 (e) A newborn child who otherwise meets the eligibility criteria for
359 the HUSKY Plan, Part B shall be eligible for benefits retroactive to his
360 or her date of birth, provided an application is filed on behalf of the
361 child [within] not later than thirty days [of] after such date. Any
362 uninsured child born in a hospital in this state or in a border state
363 hospital shall be enrolled on an expedited basis in the HUSKY Plan,
364 Part B, provided (1) the parent or caretaker relative of such child
365 resides in this state, and (2) the parent or caretaker relative of such
366 child authorizes enrollment in the program. The commissioner shall

367 pay any premium cost such family would otherwise incur for the first
368 two months of coverage to the managed care organization selected by
369 the parent or caretaker relative to provide coverage for such child.

370 (f) The commissioner shall implement presumptive eligibility for
371 children applying for Medicaid. Such presumptive eligibility
372 determinations shall be in accordance with applicable federal law and
373 regulations. The commissioner shall adopt regulations, in accordance
374 with chapter 54, to establish standards and procedures for the
375 designation of organizations as qualified entities to grant presumptive
376 eligibility. Qualified entities shall ensure that, at the time a
377 presumptive eligibility determination is made, a completed application
378 for Medicaid is submitted to the department for a full eligibility
379 determination. In establishing such standards and procedures, the
380 commissioner shall ensure the representation of state-wide and local
381 organizations that provide services to children of all ages in each
382 region of the state.

383 (g) The commissioner shall enter into a contract with an entity to be
384 a single point of entry servicer for applicants and enrollees under the
385 HUSKY Plan, Part A and Part B. [The servicer] The commissioner, in
386 consultation with the servicer, shall establish a centralized unit to be
387 responsible for processing all applications for assistance under the
388 HUSKY Plan, Part A and Part B. The department, through its contract
389 with the servicer, shall ensure that a child who is determined to be
390 eligible for benefits under the HUSKY Plan, Part A, or the HUSKY
391 Plan, Part B has uninterrupted health insurance coverage for as long as
392 the parent or guardian elects to enroll or re-enroll such child in the
393 HUSKY Plan, Part A or Part B. The commissioner, in consultation with
394 the servicer, and in accordance with the provisions of section 17b-297,
395 as amended by this act, shall jointly market both Part A and Part B
396 together as the HUSKY Plan [Such servicer] and shall develop and
397 implement public information and outreach activities with community
398 programs. Such servicer shall electronically transmit data with respect
399 to enrollment and disenrollment in the HUSKY Plan, Part A and Part B

400 to the commissioner.

401 (h) Upon the expiration of any contractual provisions entered into
402 pursuant to subsection (g) of this section, the commissioner shall
403 develop a new contract for single point of entry services and managed
404 care enrollment brokerage services. The commissioner may enter into
405 one or more contractual arrangements for such services for a contract
406 period not to exceed seven years. Such contracts shall include
407 performance measures, including, but not limited to, specified time
408 limits for the processing of applications, parameters setting forth the
409 requirements for a completed and reviewable application and the
410 percentage of applications forwarded to the department in a complete
411 and timely fashion. Such contracts shall also include a process for
412 identifying and correcting noncompliance with established
413 performance measures, including sanctions applicable for instances of
414 continued noncompliance with performance measures.

415 (i) The single point of entry servicer shall send [an application] all
416 applications and supporting documents to the commissioner for
417 determination of eligibility. [of a child who resides in a household with
418 a family income of one hundred eighty-five per cent or less of the
419 federal poverty level.] The servicer shall enroll eligible beneficiaries in
420 the applicant's choice of managed care plan. Upon enrollment in a
421 managed care plan, an eligible HUSKY Plan Part A or Part B
422 beneficiary shall remain enrolled in such managed care plan for twelve
423 months from the date of such enrollment unless (1) an eligible
424 beneficiary demonstrates good cause to the satisfaction of the
425 commissioner of the need to enroll in a different managed care plan, or
426 (2) the beneficiary no longer meets program eligibility requirements.

427 (j) Not [more than twelve] later than ten months after the
428 determination of eligibility for benefits under the HUSKY Plan, Part A
429 and Part B and annually thereafter, the commissioner or the servicer,
430 as the case may be, shall determine if the child continues to be eligible
431 for the plan. The commissioner or the servicer shall, within existing

432 budgetary resources, mail or, upon request of a participant,
433 electronically transmit an application form to each participant in the
434 plan for the purposes of obtaining information to make a
435 determination on continued eligibility beyond the twelve months of
436 initial eligibility. To the extent permitted by federal law, in
437 determining eligibility for benefits under the HUSKY Plan, Part A or
438 Part B with respect to family income, the commissioner or the servicer
439 shall rely upon information provided in such form by the participant
440 unless the commissioner or the servicer has reason to believe that such
441 information is inaccurate or incomplete. The Department of Social
442 Services shall annually review a random sample of cases to confirm
443 that, based on the statistical sample, relying on such information is not
444 resulting in ineligible clients receiving benefits under HUSKY Plan
445 Part A or Part B. The determination of eligibility shall be coordinated
446 with health plan open enrollment periods.

447 (k) The commissioner shall implement the HUSKY Plan, Part B
448 while in the process of adopting necessary policies and procedures in
449 regulation form in accordance with the provisions of section 17b-10.

450 (l) The commissioner shall adopt regulations, in accordance with
451 chapter 54, to establish residency requirements and income eligibility
452 for participation in the HUSKY Plan, Part B and procedures for a
453 simplified mail-in application process. Notwithstanding the provisions
454 of section 17b-257b, such regulations shall provide that any child
455 adopted from another country by an individual who is a citizen of the
456 United States and a resident of this state shall be eligible for benefits
457 under the HUSKY Plan, Part B upon arrival in this state.

458 Sec. 7. Section 17b-295 of the general statutes is repealed and the
459 following is substituted in lieu thereof (*Effective July 1, 2007*):

460 (a) The commissioner shall impose cost-sharing requirements,
461 including the payment of a premium or copayment, in connection with
462 services provided under the HUSKY Plan, Part B, to the extent
463 permitted by federal law, and in accordance with the following

464 limitations:

465 (1) [On and after July 1, 2005, the] The commissioner may increase
466 the maximum annual aggregate cost-sharing requirements, provided
467 such cost-sharing requirements shall not exceed five per cent of the
468 family's gross annual income. The commissioner may impose a
469 premium requirement on families whose income exceeds two hundred
470 thirty-five per cent of the federal poverty level as a component of the
471 family's cost-sharing responsibility, provided: (A) The family's annual
472 combined premiums and copayments do not exceed the maximum
473 annual aggregate cost-sharing requirement, [and] (B) premium
474 requirements for a family with income that exceeds two hundred
475 thirty-five per cent of the federal poverty level but does not exceed
476 three hundred per cent of the federal poverty level shall not exceed the
477 sum of thirty dollars per month per child, with a maximum premium
478 of fifty dollars per month per family, and (C) premium requirements
479 for a family with income that exceeds three hundred per cent of the
480 federal poverty level but does not exceed four hundred per cent of the
481 federal poverty level who does not have any access to employer-
482 sponsored health insurance coverage shall not exceed the sum of fifty
483 dollars per child, with a maximum premium of seventy-five dollars
484 per month. The commissioner shall not impose a premium
485 requirement on families whose income exceeds one hundred eighty-
486 five per cent of the federal poverty level but does not exceed two
487 hundred thirty-five per cent of the federal poverty level; and

488 (2) The commissioner shall require each managed care plan to
489 monitor copayments and premiums under the provisions of
490 subdivision (1) of this subsection.

491 (b) (1) Except as provided in subdivision (2) of this subsection, the
492 commissioner may impose limitations on the amount, duration and
493 scope of benefits under the HUSKY Plan, Part B.

494 (2) The limitations adopted by the commissioner pursuant to
495 subdivision (1) of this subsection shall not preclude coverage of any

496 item of durable medical equipment or service that is medically
497 necessary.

498 Sec. 8. Section 17b-297 of the general statutes is repealed and the
499 following is substituted in lieu thereof (*Effective July 1, 2007*):

500 (a) The commissioner, in consultation with the Children's Health
501 Council, the Medicaid Managed Care Council and the 2-1-1 Infoline [of
502 Connecticut] program, shall develop mechanisms [for outreach for] to
503 increase outreach and maximize enrollment of eligible children and
504 adults in the HUSKY Plan, Part A [and] or Part B, including, but not
505 limited to, development of mail-in applications and appropriate
506 outreach materials through the Department of Revenue Services, the
507 Labor Department, the Department of Social Services, the Department
508 of Public Health, the Department of Children and Families and the
509 Office of Protection and Advocacy for Persons with Disabilities. Such
510 mechanisms shall seek to maximize federal funds where appropriate
511 for such outreach activities.

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

515 (c) The commissioner shall, within available appropriations,
516 contract with severe need schools and community-based organizations
517 for purposes of public education, outreach and recruitment of eligible
518 children, including the distribution of applications and information
519 regarding enrollment in the HUSKY Plan, Part A and Part B. In
520 awarding such contracts, the commissioner shall consider the
521 marketing, outreach and recruitment efforts of organizations. For the
522 purposes of this subsection, (1) "community-based organizations" shall
523 include, but not be limited to, day care centers, schools, school-based
524 health clinics, community-based diagnostic and treatment centers and
525 hospitals, and (2) "severe need school" means a school in which forty
526 per cent or more of the lunches served are served to students who are
527 eligible for free or reduced price lunches.

528 (d) The commissioner, in consultation with the Latino and Puerto
529 Rican Affairs Commission, the African-American Affairs Commission,
530 representatives from minority community-based organizations and
531 any other state and local organizations deemed appropriate by the
532 commissioner, shall develop and implement outreach efforts that
533 target medically underserved children and adults, particularly Latino
534 and other minority children and adults, to increase enrollment of such
535 children and adults in the HUSKY Plan, Part A or Part B. Such efforts
536 shall include, but not be limited to, developing culturally appropriate
537 outreach materials, advertising through Latino media outlets and other
538 minority media outlets, and the public education, outreach and
539 recruitment activities described in subsections (a) to (c), inclusive, of
540 this section.

541 ~~[(d)]~~ (e) All outreach materials shall be approved by the
542 commissioner pursuant to Subtitle J of Public Law 105-33, as amended
543 from time to time.

544 ~~[(e)]~~ (f) Not later than January 1, ~~[1999]~~ 2008, and annually
545 thereafter, the commissioner shall submit a report to the Governor and
546 the General Assembly on the implementation of and the results of the
547 community-based outreach ~~[program]~~ programs specified in
548 subsections (a) to ~~[(c)]~~ (d), inclusive, of this section.

549 Sec. 9. Subsection (a) of section 17b-297b of the general statutes is
550 repealed and the following is substituted in lieu thereof (*Effective July*
551 *1, 2007*):

552 (a) To the extent permitted by federal law, the Commissioners of
553 Social Services and Education shall jointly establish procedures for the
554 sharing of information contained in applications for free and reduced
555 price meals under the National School Lunch Program for the purpose
556 of determining whether children participating in said program are
557 eligible for coverage under the HUSKY Plan, Part A and Part B. The
558 Commissioner of Social Services shall take all actions necessary to
559 ensure that children identified as eligible for either the HUSKY Plan,

560 Part A or Part B, are [able to enroll in said] enrolled in the appropriate
561 plan.

562 Sec. 10. (NEW) (*Effective July 1, 2007*) (a) Notwithstanding the
563 provisions of section 17b-299 of the general statutes, the Commissioner
564 of Social Services shall establish a health insurance premium assistance
565 program for individuals with dependent children who have income
566 that exceeds three hundred per cent of the federal poverty level but
567 does not exceed four hundred per cent of the federal poverty level and
568 who have access to employer-sponsored health insurance. Individuals
569 who elect to participate in such program shall be required to enroll
570 themselves and their dependent children in employer-sponsored
571 health insurance to the maximum extent of available coverage as a
572 condition of eligibility, provided the Department of Social Services
573 determines that enrollment in the employer-sponsored coverage is
574 more cost effective than enrolling the dependent children of such
575 individual in the HUSKY Plan, Part B.

576 (b) Any individual who elects to participate in such program shall
577 receive a health insurance premium assistance subsidy from the state
578 in an amount equal to the portion of the premium payment that is
579 attributable to the health insurance coverage for the dependent
580 children. The employer of such individual shall provide verification of
581 the cost of the health insurance premium payment that is attributable
582 to the health insurance coverage for the dependent children to the
583 Department of Social Services in a form and manner as prescribed by
584 the department. The cost of the health insurance premium payment
585 that is attributable to the health insurance coverage for the dependent
586 children shall not be deducted from such individual's weekly income,
587 but instead such cost shall be transmitted directly to and paid for by
588 the Department of Social Services. In addition, the Department of
589 Social Services shall provide to the dependents of any individual who
590 receives health insurance premium assistance in accordance with the
591 provisions of this section, HUSKY Plan, Part B coverage for medical
592 assistance or services not covered by the available employment

593 sponsored health insurance.

594 (c) The Commissioner of Social Services, pursuant to section 17b-10
595 of the general statutes, may implement policies and procedures
596 necessary to administer the provisions of this section while in the
597 process of adopting such policies and procedures as regulation,
598 provided the commissioner prints notice of the intent to adopt the
599 regulation in the Connecticut Law Journal not later than twenty days
600 after the date of implementation. Policies and procedures implemented
601 pursuant to this section shall be valid until the time final regulations
602 are adopted.

603 Sec. 11. Section 19a-88 of the general statutes is amended by adding
604 subsection (g) as follows (*Effective from passage*):

605 (NEW) (g) On or before July 1, 2008, the Department of Public
606 Health shall establish and implement a secure on-line license renewal
607 system for persons holding a license to practice medicine or surgery
608 under chapter 370, dentistry under chapter 379 or nursing under
609 chapter 378. The department shall allow any such person who renews
610 his or her license using the on-line license renewal system to pay his or
611 her professional service fees on-line by means of a credit card or
612 electronic transfer of funds from a bank or credit union account and
613 may charge such person a service fee not to exceed five dollars for any
614 such on-line payment made by credit card or electronic funds transfer.

615 Sec. 12. (NEW) (*Effective July 1, 2007*) On or before January 1, 2008,
616 the Commissioner of Social Services, shall seek a waiver under federal
617 law under the Health Insurance Flexibility and Accountability
618 demonstration proposal to provide health insurance coverage to
619 pregnant women, who do not otherwise have creditable coverage, as
620 defined in 42 USC 300gg(c), and with incomes above one hundred
621 eighty-five per cent of the federal poverty level but not in excess of two
622 hundred fifty per cent of the federal poverty level. The waiver
623 submitted by the commissioner shall specify that funding for such
624 health insurance coverage shall be provided through a reallocation of

625 unspent state children's health insurance plan funds.

626 Sec. 13. (NEW) (*Effective July 1, 2007*) (a) The Commissioner of Social
627 Services, in consultation with the Commissioner of Public Health, shall
628 develop and implement a plan for a system of preventive health
629 services for children under the HUSKY Plan, Part A and Part B. The
630 goal of the system shall be to improve health outcomes for all children
631 enrolled in the HUSKY Plan and to reduce racial and ethnic health
632 disparities among children. Such system shall ensure that services
633 under the federal Early and Periodic Screening, Diagnosis and
634 Treatment program are provided to children enrolled in the HUSKY
635 Plan, Part A.

636 (b) The plan shall:

637 (1) Establish a coordinated system for preventive health services for
638 HUSKY Plan, Part A and Part B beneficiaries including, but not limited
639 to, services under the federal Early and Periodic Screening, Diagnosis
640 and Treatment program, vision care, oral health care, care
641 coordination, chronic disease management and periodicity schedules
642 based on standards specified by the American Academy of Pediatrics;

643 (2) Require the Department of Social Services to track electronically
644 the utilization of services in the system of preventive health services by
645 HUSKY Plan, Part A and Part B beneficiaries to ensure that such
646 beneficiaries receive all the services available under the system and to
647 track the health outcomes of children; and

648 (3) Include payment methodologies to create financial incentives
649 and rewards for health care providers who participate and provide
650 services in the system, such as case management fees, pay for
651 performance, and payment for technical support and data entry
652 associated with patient registries.

653 (c) The Commissioner of Social Services shall develop the plan for a
654 system of preventive health services not later than January 1, 2008, and

655 implement the plan not later than July 1, 2008.

656 (d) Not later than July 1, 2009, the Commissioner of Social Services
657 shall report, in accordance with the provisions of section 11-4a of the
658 general statutes, to the joint standing committees of the General
659 Assembly having cognizance of matters relating to human services,
660 insurance and public health on the implementation of the plan for a
661 system of preventive health services. The report shall include
662 information on health outcomes, quality of care and methodologies
663 utilized in the plan to improve the quality of care and health outcomes
664 for children.

665 Sec. 14. (NEW) (*Effective July 1, 2007*) (a) The Commissioner of Social
666 Services, in collaboration with the Commissioners of Public Health and
667 Children and Families, shall establish a child health quality
668 improvement program for the purpose of promoting the
669 implementation of evidence-based strategies by providers
670 participating in the HUSKY Plan, Part A and Part B to improve the
671 delivery of and access to children's health services. Such strategies
672 shall focus on physical, dental and mental health services and shall
673 include, but need not be limited to: (1) Methods for early identification
674 of children with special health care needs; (2) integration of care
675 coordination and care planning into children's health services; (3)
676 implementation of standardized data collection to measure
677 performance improvement; and (4) implementation of family-centered
678 services in patient care, including, but not limited to, the development
679 of parent-provider partnerships. The Commissioner of Social Services
680 shall seek the participation of public and private entities that are
681 dedicated to improving the delivery of health services, including
682 medical, dental and mental health providers, academic professionals
683 with experience in health services research and performance
684 measurement and improvement, and any other entity deemed
685 appropriate by the Commissioner of Social Services, to promote such
686 strategies. The commissioner shall ensure that such strategies reflect
687 new developments and best practices in the field of children's health

688 services. As used in this section, "evidence-based strategies" means
689 policies, procedures and tools that are informed by research and
690 supported by empirical evidence, including, but not limited to,
691 research developed by organizations such as the American Academy
692 of Pediatrics, the American Academy of Family Physicians, the
693 National Association of Pediatric Nurse Practitioners and the Institute
694 of Medicine.

695 (b) Not later than July 1, 2008, and annually thereafter, the
696 Commissioner of Social Services shall report, in accordance with
697 section 11-4a of the general statutes, to the joint standing committees of
698 the General Assembly having cognizance of matters relating to human
699 services, public health and appropriations, and to the Medicaid
700 Managed Care Council on (1) the implementation of any strategies
701 developed pursuant to subsection (a) of this section, and (2) the
702 efficacy of such strategies in improving the delivery of and access to
703 health services for children enrolled in the HUSKY Plan.

704 Sec. 15. Section 38a-482 of the general statutes is repealed and the
705 following is substituted in lieu thereof (*Effective July 1, 2007*):

706 No individual health insurance policy shall be delivered or issued
707 for delivery to any person in this state unless: (1) The entire money and
708 other considerations therefor are expressed therein; (2) the time at
709 which the insurance takes effect and terminates is expressed therein;
710 (3) such policy purports to insure only one person, except that a policy
711 may insure, originally or by subsequent amendment, upon the
712 application of an adult member of a family, who shall be deemed the
713 policyholder, any two or more eligible members of such family,
714 including husband, wife, dependent children or any children [under a
715 specified age, which shall not exceed eighteen years] as specified in
716 section 38a-497, as amended by this act, and any other person
717 dependent upon the policyholder; (4) the style, arrangement and
718 overall appearance of the policy give no undue prominence to any
719 portion of the text, and every printed portion of the text of the policy

720 and of any endorsements or attached papers is plainly printed in light-
721 faced type of a style in general use, the size of which shall be uniform
722 and not less than ten-point with a lowercase unspaced alphabet length
723 not less than one hundred and twenty-point, the word "text" as herein
724 used including all printed matter except the name and address of the
725 insurer, name or title of the policy, the brief description, if any, and
726 captions and subcaptions; (5) the exceptions and reductions of
727 indemnity are set forth in the policy and, except as provided in section
728 38a-483, are printed, at the insurer's option, either included with the
729 benefit provision to which they apply, or under an appropriate caption
730 such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS",
731 provided, if an exception or reduction specifically applies only to a
732 particular benefit of the policy, a statement of such exception or
733 reduction shall be included with the benefit provision to which it
734 applies; (6) each such form, including riders and endorsements, shall
735 be identified by a form number in the lower left-hand corner of the
736 first page thereof; and (7) such policy contains no provision purporting
737 to make any portion of the charter, rules, constitution or bylaws of the
738 insurer a part of the policy unless such portion is set forth in full in the
739 policy, except in the case of the incorporation of, or reference to, a
740 statement of rates or classification of risks, or short-rate table filed with
741 the commissioner.

742 Sec. 16. Section 38a-497 of the general statutes is repealed and the
743 following is substituted in lieu thereof (*Effective July 1, 2007*):

744 Every individual health insurance policy providing coverage of the
745 type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of
746 section 38a-469 delivered, issued for delivery, amended or renewed in
747 this state on or after October 1, [1982] 2007, shall provide that coverage
748 of a child shall terminate no earlier than the policy anniversary date on
749 or after whichever of the following occurs first, the date on which the
750 child marries, ceases to be a [dependent of the policyholder,] resident
751 of the state or attains the age of [nineteen if the child is not a full-time
752 student at an accredited institution, or attains the age of twenty-three if

753 the child is a full-time student at an accredited institution] twenty-six.

754 Sec. 17. Section 38a-554 of the general statutes is repealed and the
755 following is substituted in lieu thereof (*Effective July 1, 2007*):

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

759 (a) The plan shall be one under which the individuals eligible to be
760 covered include: (1) Each eligible employee; (2) the spouse of each
761 eligible employee, who shall be considered a dependent for the
762 purposes of this section; and (3) [dependent] unmarried children
763 residing in the state, who are under [the age of nineteen or are full-
764 time students under the age of twenty-three at an accredited institution
765 of higher learning] twenty-six years of age.

766 (b) The plan shall provide the option to continue coverage under
767 each of the following circumstances until the individual is eligible for
768 other group insurance, except as provided in subdivisions (3) and (4)
769 of this subsection: (1) Notwithstanding any provision of this section,
770 upon layoff, reduction of hours, leave of absence, or termination of
771 employment, other than as a result of death of the employee or as a
772 result of such employee's "gross misconduct" as that term is used in 29
773 USC 1163(2), continuation of coverage for such employee and such
774 employee's covered dependents for the periods set forth for such event
775 under federal extension requirements established by the federal
776 Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272),
777 as amended from time to time, (COBRA), except that if such reduction
778 of hours, leave of absence or termination of employment results from
779 an employee's eligibility to receive Social Security income,
780 continuation of coverage for such employee and such employee's
781 covered dependents until midnight of the day preceding such person's
782 eligibility for benefits under Title XVIII of the Social Security Act; (2)
783 upon the death of the employee, continuation of coverage for the
784 covered dependents of such employee for the periods set forth for such

785 event under federal extension requirements established by the
786 Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272),
787 as amended from time to time, (COBRA); (3) regardless of the
788 employee's or dependent's eligibility for other group insurance, during
789 an employee's absence due to illness or injury, continuation of
790 coverage for such employee and such employee's covered dependents
791 during continuance of such illness or injury or for up to twelve months
792 from the beginning of such absence; (4) regardless of an individual's
793 eligibility for other group insurance, upon termination of the group
794 plan, coverage for covered individuals who were totally disabled on
795 the date of termination shall be continued without premium payment
796 during the continuance of such disability for a period of twelve
797 calendar months following the calendar month in which the plan was
798 terminated, provided claim is submitted for coverage within one year
799 of the termination of the plan; (5) the coverage of any covered
800 individual shall terminate: (A) As to a child, the plan shall provide the
801 option for said child to continue coverage for the longer of the
802 following periods: (i) At the end of the month following the month in
803 which the child marries, ceases to [be dependent on the employee]
804 reside in the state or attains the age of [nineteen, whichever occurs
805 first, except that if the child is a full-time student at an accredited
806 institution, the coverage may be continued while the child remains
807 unmarried and a full-time student, but not beyond the month
808 following the month in which the child attains the age of twenty-three]
809 twenty-six. If on the date specified for termination of coverage on a
810 [dependent] child, the child is unmarried and incapable of self-
811 sustaining employment by reason of mental or physical handicap and
812 chiefly dependent upon the employee for support and maintenance,
813 the coverage on such child shall continue while the plan remains in
814 force and the child remains in such condition, provided proof of such
815 handicap is received by the carrier within thirty-one days of the date
816 on which the child's coverage would have terminated in the absence of
817 such incapacity. The carrier may require subsequent proof of the
818 child's continued incapacity and dependency but not more often than

819 once a year thereafter, or (ii) for the periods set forth for such child
820 under federal extension requirements established by the Consolidated
821 Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended
822 from time to time, (COBRA); (B) as to the employee's spouse, at the
823 end of the month following the month in which a divorce, court-
824 ordered annulment or legal separation is obtained, whichever is
825 earlier, except that the plan shall provide the option for said spouse to
826 continue coverage for the periods set forth for such events under
827 federal extension requirements established by the Consolidated
828 Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended
829 from time to time, (COBRA); and (C) as to the employee or dependent
830 who is sixty-five years of age or older, as of midnight of the day
831 preceding such person's eligibility for benefits under Title XVIII of the
832 federal Social Security Act; (6) as to any other event listed as a
833 "qualifying event" in 29 USC 1163, as amended from time to time,
834 continuation of coverage for such periods set forth for such event in 29
835 USC 1162, as amended from time to time, provided such plan may
836 require the individual whose coverage is to be continued to pay up to
837 the percentage of the applicable premium as specified for such event in
838 29 USC 1162, as amended from time to time. Any continuation of
839 coverage required by this section except subdivision (4) or (6) of this
840 subsection may be subject to the requirement, on the part of the
841 individual whose coverage is to be continued, that such individual
842 contribute that portion of the premium the individual would have
843 been required to contribute had the employee remained an active
844 covered employee, except that the individual may be required to pay
845 up to one hundred two per cent of the entire premium at the group
846 rate if coverage is continued in accordance with subdivision (1), (2) or
847 (5) of this subsection. The employer shall not be legally obligated by
848 sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, to pay such
849 premium if not paid timely by the employee.

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

853 (d) The plan shall make available to Connecticut residents, in
854 addition to any other conversion privilege available, a conversion
855 privilege under which coverage shall be available immediately upon
856 termination of coverage under the group plan. The terms and benefits
857 offered under the conversion benefits shall be at least equal to the
858 terms and benefits of an individual comprehensive health care plan.

859 Sec. 18. Subdivision (19) of section 38a-564 of the general statutes is
860 repealed and the following is substituted in lieu thereof (*Effective July*
861 *1, 2007*):

862 (19) "Low-income eligible employee" means an eligible employee of
863 a small employer whose annualized wages from such small employer
864 determined as of the effective date of the special health care plan or as
865 of any anniversary of such effective date as certified to the insurer or
866 insurance arrangement or the Health Reinsurance Association, as the
867 case may be, by such small employer is less than [two] three hundred
868 per cent of the federal poverty level applicable to such person.

869 Sec. 19. Subdivision (24) of section 38a-564 of the general statutes is
870 repealed and the following is substituted in lieu thereof (*Effective July*
871 *1, 2007*):

872 (24) "Low-income individual" means an individual whose adjusted
873 gross income (AGI) for the individual and spouse, from the most
874 recent federal tax return filed prior to the date of application for the
875 individual special health care plan or prior to any anniversary of the
876 effective date of the plan, as certified by such individual, is less than
877 [two] three hundred per cent of the applicable federal poverty level.

878 Sec. 20. Subsection (b) of section 38a-565 of the general statutes is
879 repealed and the following is substituted in lieu thereof (*Effective July*
880 *1, 2007*):

881 (b) (1) Within ninety days after approval by the commissioner of
882 special health care plans submitted by the board, every small employer

883 carrier shall, as a condition of transacting such business in this state,
884 offer small employers a special health care plan, provided no small
885 employer carrier may be required to offer a special health care plan to
886 a small employer with ten or fewer eligible employees, the majority of
887 whom are low-income eligible employees. Such employers may
888 purchase a special health care plan from the Health Reinsurance
889 Association pursuant to section 38a-570. Small employer carriers that
890 do not offer special health care plans to such employers shall refer
891 those employers to the Health Reinsurance Association. Except as
892 provided in subdivision (2) of this subsection, every small employer
893 which elects to be covered under a special health care plan and agrees
894 to make the required premium payments and to satisfy the other
895 provisions of the plan shall be issued such a plan by the small
896 employer carrier or the Health Reinsurance Association, as the case
897 may be.

898 (2) No small employer may be eligible to purchase a special health
899 care plan unless such employer had maintained no health insurance
900 coverage for its employees at any time during the one-year period
901 ending on the date of application for such policy. No small employer
902 may purchase a special health care plan for more than three years.

903 [(3) No special health care plan may be sold with an initial effective
904 date of January 1, 1995, or later.]

905 [(4)] (3) In addition to any other requirements related to the
906 establishment of premiums for special health care plans issued by
907 small employer carriers to small employers, (A) the anticipated loss
908 ratio shall not be less than seventy-five per cent of the premium, and
909 (B) small employer carriers shall file annually by the end of March of
910 each year information with the Insurance Department with respect to
911 such plans for the prior calendar year including the number of plans
912 issued, the anticipated loss ratio, the premiums earned, the paid and
913 estimated outstanding claims, expenses charged, and such other
914 information as the commissioner deems necessary to assure

915 compliance with subparagraph (A) of this subdivision.

916 [(5)] (4) A health care center shall not be required to offer coverage
917 or accept applications pursuant to subdivision (1) of this subsection in
918 the case of any of the following: (A) To a group, where the group is not
919 physically located in the health care center's approved service area; (B)
920 to an employee, where the employee does not work or reside within
921 the health care center's approved service area; (C) within an area
922 where the health care center reasonably anticipates, and demonstrates
923 to the satisfaction of the commissioner, that it will not have the
924 capacity within that area in its network of providers to deliver services
925 adequately to the members of such groups because of its obligations to
926 existing group contract holders and enrollees; (D) where the
927 commissioner finds that acceptance of an application or applications
928 would place the health care center in an impaired financial condition;
929 or (E) to groups of fewer than three eligible employees, where the
930 health care center does not utilize preexisting condition provisions in
931 the plans it issues to any small employers. A health care center that
932 refuses to offer coverage pursuant to subparagraph (C) of this
933 subdivision may not, for ninety days after such refusal, offer coverage
934 in the applicable area to new cases of employer groups with more than
935 twenty-five eligible employees.

936 [(6)] (5) A small employer carrier shall not be required to offer
937 coverage or accept applications pursuant to subdivision (1) of this
938 subsection subject to the following conditions: (A) The small employer
939 carrier ceases to market health insurance or health benefit plans to
940 small employers and ceases to enroll small employers under existing
941 health insurance or health benefit plans; (B) the small employer carrier
942 notifies the commissioner of its decision to cease marketing to small
943 employers and to cease enrolling small employers, as provided in
944 subparagraph (A) of this subdivision; and (C) the small employer
945 carrier is prohibited from reentering the small employer market for a
946 period of five years from the date of the notice required under
947 subparagraph (B) of this subdivision.

948 Sec. 21. Section 38a-570 of the general statutes is repealed and the
949 following is substituted in lieu thereof (*Effective July 1, 2007*):

950 Notwithstanding the provisions of sections 38a-505, 38a-546 and
951 38a-551 to 38a-559, inclusive, the Health Reinsurance Association may
952 issue special health care plans to small employers with ten or fewer
953 eligible employees, the majority of whom are low-income eligible
954 employees. The following provisions shall apply to such special health
955 care plans:

956 (1) Premium rates shall be promulgated by the board of directors of
957 the Health Reinsurance Association based on recommendations of its
958 actuarial committee. In developing recommendations for premium
959 rates, the actuarial committee shall consider, in addition to other
960 pertinent matters, the premiums that are or would be charged for the
961 same or similar insurance by other insurers. Except as otherwise
962 provided in sections 38a-564 to 38a-572, inclusive, in establishing
963 premium rates the board of directors of the Health Reinsurance
964 Association may consider any relevant factors impacting premium,
965 claims and expenses, including characteristics of small employers and
966 insureds, that may be considered by any insurer in establishing health
967 insurance premium rates. The premium rates established shall be
968 subject to the provisions of section 38a-567. The anticipated loss ratio
969 shall not be less than eighty per cent of the premium. In establishing
970 premium rates [it shall be the goal of] the board of directors of the
971 Health Reinsurance Association [to] shall administer special health
972 care plans issued to small employers without gain or loss; and

973 (2) The Health Reinsurance Association may reinsure coverage of
974 special health care plans with the pool.

975 Sec. 22. Section 38a-1041 of the general statutes is amended by
976 adding subsection (f) as follows (*Effective October 1, 2007*):

977 (NEW) (f) On or before October 1, 2008, the Office of the Healthcare
978 Advocate shall, within available appropriations, establish and

979 maintain a healthcare consumer information web site on the Internet
980 for use by the public in obtaining healthcare information, including but
981 not limited to: (1) The availability of wellness programs in various
982 regions of Connecticut, such as disease prevention and health
983 promotion programs; (2) quality and experience data from hospitals
984 licensed in this state; and (3) a link to the consumer report card
985 developed and distributed by the Insurance Commissioner pursuant to
986 section 38a-478l.

987 Sec. 23. (NEW) (*Effective October 1, 2007*) Any employer that
988 provides health insurance benefits to its employees for which any
989 portion of the premiums are deducted from the employees' pay shall
990 offer such employees the opportunity to have such portion excluded
991 from their gross income for state or federal income tax purposes,
992 except as required under Section 125 of the Internal Revenue Code of
993 1986, or any subsequent corresponding internal revenue code of the
994 United States, as from time to time amended.

995 Sec. 24. (NEW) (*Effective July 1, 2007*) eHealth Connecticut shall be
996 designated the lead health information exchange organization for the
997 state of Connecticut for the period commencing July 1, 2007, and
998 ending July 1, 2012. The Commissioner of Public Health shall contract
999 with such organization to develop a state-wide health information
1000 technology plan, which includes development of standards, protocols
1001 and pilot programs for health information exchange.

1002 Sec. 25. (NEW) (*Effective July 1, 2007*) (a) As used in this section:

1003 (1) "Electronic health information system" means an information
1004 processing system, involving both computer hardware and software
1005 that deals with the storage, retrieval, sharing and use of health care
1006 information, data and knowledge for communication and decision
1007 making, and includes: (A) An electronic health record that provides
1008 access in real-time to a patient's complete medical record; (B) a
1009 personal health record through which an individual, and anyone
1010 authorized by such individual, can maintain and manage such

1011 individual's health information; (C) computerized order entry
1012 technology that permits a health care provider to order diagnostic and
1013 treatment services, including prescription drugs electronically; (D)
1014 electronic alerts and reminders to health care providers to improve
1015 compliance with best practices, promote regular screenings and other
1016 preventive practices, and facilitate diagnoses and treatments; (E) error
1017 notification procedures that generate a warning if an order is entered
1018 that is likely to lead to a significant adverse outcome for a patient; and
1019 (F) tools to allow for the collection, analysis and reporting of data on
1020 adverse events, near misses, the quality and efficiency of care, patient
1021 satisfaction and other healthcare-related performance measures.

1022 (2) "Interoperability" means the ability of two or more systems or
1023 components to exchange information and to use the information that
1024 has been exchanged and includes: (A) The capacity to physically
1025 connect to a network for the purpose of exchanging data with other
1026 users; (B) the ability of a connected user to demonstrate appropriate
1027 permissions to participate in the instant transaction over the network;
1028 and (C) the capacity of a connected user with such permissions to
1029 access, transmit, receive and exchange usable information with other
1030 users.

1031 (3) "Standard electronic format" means a format using open
1032 electronic standards that: (A) Enable health information technology to
1033 be used for the collection of clinically specific data; (B) promote the
1034 interoperability of health care information across health care settings,
1035 including reporting to local, state and federal agencies; and (C)
1036 facilitate clinical decision support.

1037 (b) On or before July 1, 2008, the Department of Public Health, in
1038 consultation with the Departments of Social Services and Information
1039 Technology, and any other entity deemed appropriate by the
1040 Commissioner of Public Health, shall develop electronic data
1041 standards to facilitate the development of a state-wide, integrated
1042 electronic health information system for use by health care providers

1043 and institutions that are funded by the state. The electronic data
1044 standards shall (1) include provisions relating to security, privacy, data
1045 content, structures and format, vocabulary and transmission protocols,
1046 (2) be compatible with any national data standards in order to allow
1047 for interstate interoperability, (3) permit the collection of health
1048 information in a standard electronic format, and (4) be compatible with
1049 the requirements for an electronic health information system.

1050 (c) The Department of Public Health may contract for the
1051 development of the electronic data standards through a request for
1052 proposals process.

1053 (d) Not later than October 1, 2008, the department shall report, in
1054 accordance with section 11-4a of the general statutes, to the joint
1055 standing committees of the General Assembly having cognizance of
1056 matters relating to public health, human services, government
1057 administration and appropriations on the electronic data standards
1058 developed pursuant to subsection (b) of this section.

1059 Sec. 26. (NEW) (*Effective October 1, 2007*) (a) There is established at
1060 The University of Connecticut Health Center a Connecticut Health
1061 Information Network, which shall securely integrate state health and
1062 social services data, consistent with state and federal privacy laws,
1063 within and across The University of Connecticut Health Center, the
1064 Office of Health Care Access and the Departments of Public Health,
1065 Mental Retardation and Children and Families. Data from other state
1066 agencies may be integrated into the network as funding permits and as
1067 permissible under federal law.

1068 (b) The Center for Public Health and Health Policy at The
1069 University of Connecticut Health Center, in collaboration with the
1070 Departments of Information Technology, Public Health, Mental
1071 Retardation, Children and Families and the Office of Health Care
1072 Access shall develop, implement and administer the Connecticut
1073 Health Information Network.

1074 (c) The Connecticut Health Information Network shall develop a
1075 framework for creating the Connecticut Community Health Data and
1076 Information Portal, which shall be capable of providing (1) access to
1077 public use datasets containing health and social services information
1078 concerning Connecticut residents, maintained by state agencies and
1079 other nongovernmental entities, and (2) a platform to query the
1080 network to obtain aggregate data on key health indicators within the
1081 state. The Connecticut Community Health Data and Information Portal
1082 shall be designed to:

1083 (A) Provide accurate, timely and accessible health data to public and
1084 private sector leaders and policy makers at the state and local level,
1085 and inform citizens to improve community and individual health;

1086 (B) Adhere to strict confidentiality and privacy standards;

1087 (C) Support efforts to reduce health disparities; and

1088 (D) Identify the best available data sources and coordinate the
1089 compilation of extant health-related data and statistics.

1090 Sec. 27. (NEW) (*Effective October 1, 2007*) (a) There is established a
1091 Connecticut Health Information Network Governing Board to oversee
1092 the Connecticut Health Information Network established under section
1093 26 of this act.

1094 (b) The governing board shall consist of the following members:

1095 (1) One appointed by the Governor, who shall serve as the
1096 chairperson;

1097 (2) One appointed by the speaker of the House of Representatives;

1098 (3) One appointed by the president pro tempore of the Senate;

1099 (4) One appointed by the majority leader of the House of
1100 Representatives who shall represent consumers;

1101 (5) One appointed by the minority leader of the House of
1102 Representatives who shall represent data users;

1103 (6) One appointed by the majority leader of the Senate, who shall be
1104 a local director of health;

1105 (7) One appointed by the minority leader of the Senate, who shall be
1106 a privacy advocate;

1107 (8) One appointed by The University of Connecticut Health Center;
1108 and

1109 (9) The Commissioners of Public Health, Mental Retardation,
1110 Children and Families and Health Care Access and the Chief
1111 Information Officer of the Department of Information Technology shall
1112 be ex-officio, nonvoting members.

1113 (c) All initial appointments to the board shall be made not later than
1114 November 30, 2007. The term of each appointed governing board
1115 member shall be four years or until a successor is chosen, whichever is
1116 later. Any vacancy shall be filled by the appointing authority.

1117 (d) The chairperson shall schedule the first meeting of the board,
1118 which shall be held not later than December 31, 2007.

1119 (e) The governing board shall meet at least once during each
1120 calendar quarter and at such other times as the chairperson deems
1121 necessary. A majority of the members shall constitute a quorum for the
1122 transaction of business.

1123 (f) The duties and responsibilities of the governing board shall be to:
1124 (1) Establish and implement policies, procedures and protocols
1125 governing access and dissemination of data through the Connecticut
1126 Health Information Network; (2) establish such permanent and ad hoc
1127 committees as it deems necessary to facilitate the implementation,
1128 operation and maintenance of the network; (3) recommend any
1129 legislation necessary for implementation, operation and maintenance

1130 of the network; (4) perform all necessary functions to facilitate the
1131 coordination and integration of the network; and (5) report annually to
1132 the Governor and the General Assembly on the status and operations
1133 of the Connecticut Health Information Network, including any
1134 recommendations for funding.

1135 Sec. 28. (NEW) (*Effective October 1, 2007*) (a) Notwithstanding any
1136 provision of chapter 14, 319, 319b, 319o, 319s, 319t, 319v or 368a of the
1137 general statutes, or any regulation adopted pursuant to said chapters,
1138 and subject to federal restrictions on disclosure or redisclosure of such
1139 information, the state agencies that participate in the Connecticut
1140 Health Information Network may disclose personally identifiable
1141 information held in agency databases to the administrator of the
1142 Connecticut Health Information Network and its subcontractors for
1143 the purposes of (1) network development and verification, and (2) data
1144 integration and aggregation to enable response to network queries
1145 approved by the commissioner of the department with primary
1146 responsibility for collecting or maintaining such information. Such
1147 approval shall not be denied unless disclosure of such personally
1148 identifiable information to the Connecticut Health Information
1149 Network would constitute a violation of federal law, including, but not
1150 limited to, the Health Insurance Portability and Accountability Act of
1151 1996 (P.L. 104-191) (HIPAA), as amended from time to time, and the
1152 Family Educational Rights and Privacy Act of 1974, 20 USC 1232g,
1153 (FERPA), as amended from time to time, and any regulations
1154 promulgated thereunder at 34 CFR Part 99.

1155 (b) The Connecticut Health Information Network may use such
1156 personally identifiable information for the purposes of (1) matching
1157 data across or within participating agency databases, including
1158 selected health databases at The University of Connecticut Health
1159 Center, and (2) providing data without personally identifiable
1160 information in response to queries approved by the Connecticut
1161 Health Information Network Governing Board. The network may not
1162 redisclose such personally identifiable information, except when and

1163 as permitted by written agreements with state agencies or other
1164 network contributors that expressly authorize redisclosure of
1165 personally identifiable information, subject to all applicable state and
1166 federal laws. Neither the network nor any recipient of data from the
1167 network may redisclose such data in a manner that would disclose
1168 personally identifiable information or the identification of any
1169 individual to whom such data pertains.

1170 Sec. 29. (*Effective from passage*) Not later than January 1, 2008, the
1171 Department of Social Services shall inventory and report, in
1172 accordance with the provisions of section 11-4a of the general statutes,
1173 on all disease management initiatives implemented as of the effective
1174 date of this section under the HUSKY Plan, Part A, the HUSKY Plan,
1175 Part B, the state-administered general assistance program and the state
1176 Medicaid plan to the joint standing committees of the General
1177 Assembly having cognizance of matters relating to public health and
1178 human services. Such report shall include a summary of each
1179 initiative, the total amount of money spent on each initiative, from
1180 inception, and the total number of persons served by each initiative.

1181 Sec. 30. (NEW) (*Effective from passage*) (a) There is established a
1182 HealthFirst Connecticut Authority composed of the following
1183 members: Two appointed by the speaker of the House of
1184 Representatives, one of whom is a health care provider and one of
1185 whom represents businesses with fifty or more employees; two
1186 appointed by the president pro tempore of the Senate, one of whom
1187 has experience in community-based health care and one of whom
1188 represents businesses with fewer than fifty employees; one appointed
1189 by the majority leader of the House of Representatives who represents
1190 consumers; one appointed by the majority leader of the Senate who
1191 represents the interests of labor; one appointed by the minority leader
1192 of the House of Representatives who represents health insurance
1193 companies; one appointed by the minority leader of the Senate who
1194 represents hospitals; and two appointed by the Governor, one of
1195 whom advocates for health care quality or patient safety and one with

1196 experience in information technology. The Commissioners of Public
1197 Health and Social Services or their designees and the Comptroller or
1198 Comptroller's designee shall be ex-officio, non voting members.

1199 (b) All appointments to the HealthFirst Connecticut Authority shall
1200 be made not later than thirty days after the effective date of this section
1201 and any vacancy shall be filled by the appointing authority not later
1202 than thirty days after the vacancy. If an appointing authority fails to
1203 make an appointment within any such thirty-day period, the
1204 chairpersons of the HealthFirst Connecticut Authority shall make such
1205 appointment.

1206 (c) The speaker of the House of Representatives and the president
1207 pro tempore of the Senate shall each select a chairperson of the
1208 HealthFirst Connecticut Authority from among the members of the
1209 authority. Such chairpersons shall schedule the first meeting of the
1210 HealthFirst Connecticut Authority, which shall be held not later than
1211 sixty days after the effective date of this section.

1212 (d) All members appointed to the authority shall be familiar with
1213 the criteria of the Institute of Medicine of the National Academies
1214 Principals for Healthcare Reform and shall be committed to making
1215 recommendations about health care reform for the state of Connecticut
1216 that are consistent with said criteria.

1217 (e) The HealthFirst Connecticut Authority shall:

1218 (1) Examine and evaluate policy alternatives for providing quality,
1219 affordable and sustainable health care for all individuals residing in
1220 this state, including, but not limited to, a state-wide single payer health
1221 care system and employer-sponsored health plans.

1222 (2) Make recommendations for mechanisms to contain the cost and
1223 improve the quality of health care in this state, including, but not
1224 limited to: Health information technology; disease management and
1225 other initiatives to coordinate and improve the quality of care for

1226 people with chronic diseases; monitoring and reporting about the
1227 costs, quality and utilization of care, including assessment of consumer
1228 and provider satisfaction; and measures to encourage or require the
1229 provision of health care coverage to certain groups through
1230 participation in an insurance pool.

1231 (3) Make recommendations regarding the financing of quality,
1232 affordable health care coverage for individuals residing in this state,
1233 including the maximization of federal funds to provide subsidies for
1234 health care, contributions from employers, employees and individuals
1235 and methods for financing the state's share of the cost of such
1236 coverage.

1237 (4) Not later than December 1, 2008, report on its findings and
1238 recommendations with respect to such policy alternatives to the joint
1239 standing committees of the General Assembly having cognizance of
1240 matters relating to public health, social services and insurance, in
1241 accordance with the provisions of section 11-4a of the general statutes.
1242 Such report shall include recommended strategies for increasing access
1243 to health care for all of Connecticut's residents.

1244 (f) The HealthFirst Connecticut Authority may apply for grants or
1245 financial assistance from any person, group of persons or corporation
1246 or from any agency of the state or of the United States.

1247 Sec. 31. (NEW) (*Effective from passage*) (a) There is established a State-
1248 wide Primary Care Access Authority. The authority shall consist of the
1249 Commissioners of Public Health and Social Services, the Comptroller,
1250 the chairpersons of the HealthFirst Connecticut Authority established
1251 under section 30 of this act and the following members: One each
1252 appointed by the Connecticut Primary Care Association, the
1253 Connecticut State Medical Society, the Connecticut Chapter of the
1254 American Academy of Pediatrics, the Connecticut Nurses Association,
1255 the Connecticut Association of School Based Health Centers and the
1256 Weitzman Center for Innovation In Community Health and Primary
1257 Care. Members shall serve for a term of four years commencing on

1258 August 1, 2007. All initial appointments to the committee shall be
1259 made by July 15, 2007. Any vacancy shall be filled by the appointing
1260 authority.

1261 (b) The chairpersons of the HealthFirst Connecticut Authority
1262 established under section 30 of this act shall serve as cochairpersons of
1263 the State-wide Primary Care Access Authority. Members shall serve
1264 without compensation but shall, within available appropriations, be
1265 reimbursed for expenses necessarily incurred in the performance of
1266 their duties.

1267 (c) The chairpersons shall convene the first meeting of the State-
1268 wide Primary Care Access Authority not later than October 1, 2007.
1269 Any member who fails to attend three consecutive meetings or who
1270 fails to attend fifty per cent of all meetings held during any calendar
1271 year shall be deemed to have resigned from the committee.

1272 (d) All members appointed to the authority shall be familiar with
1273 the criteria of the Institute of Medicine of the National Academies
1274 Principles for Healthcare Reform and shall be committed to making
1275 recommendations about health care reform for the state of Connecticut
1276 that are consistent with said criteria.

1277 (e) The State-wide Primary Care Access Authority shall:

1278 (1) Determine what constitutes primary care services for purposes of
1279 subdivisions (2) to (4), inclusive, of this section;

1280 (2) Inventory the state's existing primary care infrastructure,
1281 including, but not limited to, (A) the number of primary care providers
1282 practicing in the state, (B) the total amount of money expended on
1283 public and private primary care services during the last fiscal year, (C)
1284 the number of public and private buildings or offices used primarily
1285 for the rendering of primary care services, including, but not limited
1286 to, hospitals, mental health facilities, dental offices, school-based health
1287 clinics, community-based health centers and academic health centers.

1288 For the purposes of this subdivision, "primary care provider" means
1289 any physician, dentist, nurse, provider of services for the mentally ill
1290 or persons with mental retardation, or other person involved in
1291 providing primary medical, nursing, counseling, or other health care,
1292 substance abuse or mental health service, including such services
1293 associated with, or under contract to, a health maintenance
1294 organization or medical services plan.

1295 (3) Not later than December 31, 2008, develop a universal system for
1296 providing primary care services, including prescription drugs, to all
1297 residents of the state that maximizes federal financial participation in
1298 Medicaid and Medicare. The committee shall (A) estimate the cost of
1299 fully implementing such universal system, (B) identify any additional
1300 infrastructure or personnel that would be necessary in order to fully
1301 implement such universal system, (C) determine the state's role and
1302 the role of third party entities in administering such universal system,
1303 (D) identify funding sources for such universal system, and (E)
1304 determine the role of private health insurance in such universal
1305 system.

1306 (4) Develop a plan for implementing by July 1, 2010, the universal
1307 primary care system developed pursuant to subdivision (3) of this
1308 section. Such plan shall (A) include a timetable for implementation of
1309 the universal primary care system, (B) establish benchmarks to assess
1310 the state's progress in implementing the system, and (C) establish
1311 mechanisms for assessing the effectiveness of the primary care system,
1312 once implemented.

1313 (f) The State-wide Primary Care Access Authority may (1) retain
1314 and employ consultants or assistants on a contract or other basis for
1315 rendering professional, legal, financial, technical or other assistance or
1316 advice as may be required to carry out its duties or responsibilities,
1317 and (2) apply for grants or financial assistance from any person, group
1318 of persons or corporation or from any agency of the state or of the
1319 United States.

1320 (g) On or before February 1, 2008, and annually thereafter on or
1321 before January first, the State-wide Primary Care Access Authority
1322 shall report to the joint standing committees of the General Assembly
1323 having cognizance of matters relating to public health, insurance and
1324 human services, in accordance with the provisions of section 11-4a of
1325 the general statutes, concerning its progress in developing the
1326 universal primary care services system and the implementation plan
1327 for such system.

1328 Sec. 32. (NEW) (*Effective from passage*) The committee established
1329 under section 51 of public act 06-195 shall meet at least once every
1330 calendar quarter and report annually to the joint standing committees
1331 of the General Assembly having cognizance of matters relating to
1332 public health and education, in accordance with the provisions of
1333 section 11-4a of the general statutes, on recommended statutory and
1334 regulatory changes to improve health care through access to school-
1335 based health clinics.

1336 Sec. 33. (NEW) (*Effective July 1, 2007*) Any school-based health clinic
1337 constructed on or after October 1, 2007, that is located in or attached to
1338 a school building shall be constructed with an entrance that is separate
1339 from the entrance to the school building.

1340 Sec. 34. (NEW) (*Effective July 1, 2007*) For the fiscal year ending June
1341 30, 2008, and annually thereafter, the Department of Social Services
1342 shall, within existing budgetary resources, increase the rates paid to
1343 Medicaid providers and hospitals that provide services to Medicaid
1344 recipients.

1345 Sec. 35. (*Effective July 1, 2007*) The sum of one hundred fifty
1346 thousand dollars is appropriated to the Department of Social Services,
1347 from the General Fund, for the fiscal year ending June 30, 2008, for the
1348 purposes of section 14 of this act.

1349 Sec. 36. (*Effective July 1, 2007*) The sum of two hundred fifty
1350 thousand dollars is appropriated to the Department of Public Health,

1351 from the General Fund, for the fiscal year ending June 30, 2008, for the
1352 purposes of section 25 of this act.

1353 Sec. 37. (*Effective July 1, 2007*) The sum of one million dollars is
1354 appropriated to The University of Connecticut Health Center, from the
1355 General Fund, for the fiscal year ending June 30, 2008, for the purpose
1356 of establishing and operating the Connecticut Health Information
1357 Network established under section 26 of this act.

1358 Sec. 38. (*Effective July 1, 2008*) The sum of one million dollars is
1359 appropriated to The University of Connecticut Health Center, from the
1360 General Fund, for the fiscal year ending June 30, 2009, for the purpose
1361 of operating the Connecticut Health Information Network established
1362 under section 26 of this act.

1363 Sec. 39. (*Effective July 1, 2008*) The sum of five hundred thousand
1364 dollars is appropriated to the Department of Public Health, from the
1365 General Fund, for the fiscal year ending June 30, 2009, for the
1366 HealthFirst Authority established pursuant to section 30 of this act.

1367 Sec. 40. (*Effective July 1, 2008*) The sum of five hundred thousand
1368 dollars is appropriated to the Department of Public Health, from the
1369 General Fund, for the fiscal year ending June 30, 2009, for the State-
1370 wide Primary Care Access Authority established pursuant to section
1371 31 of this act.

1372 Sec. 41. (*Effective July 1, 2007*) The sum of two million five hundred
1373 thousand dollars is appropriated to the Department of Public Health,
1374 from the General Fund, for the fiscal year ending June 30, 2008, for the
1375 expansion and operation of school-based health clinics for priority
1376 school districts pursuant to section 10-266p of the general statutes and
1377 areas designated by the federal Health Resources and Services
1378 Administration as health professional shortage areas, medically
1379 underserved areas or areas with a medically underserved population.

1380 Sec. 42. (*Effective July 1, 2007*) The sum of five hundred thousand

1381 dollars is appropriated to the Department of Public Health, from the
 1382 General Fund, for the fiscal year ending June 30, 2008, for grants to
 1383 community-based health centers to provide transportation assistance
 1384 to patients for medical appointments. Priority shall be given to
 1385 federally-qualified health centers located in areas of the state with
 1386 limited public transportation options.

1387 Sec. 43. (*Effective July 1, 2007*) The sum of two million dollars is
 1388 appropriated to the Department of Public Health, from the General
 1389 Fund, for the fiscal year ending June 30, 2008, for grants to community-
 1390 based health centers for infrastructure improvements, including, but
 1391 not limited to, health information technology.

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-192
Sec. 3	<i>July 1, 2007</i>	17b-261
Sec. 4	<i>July 1, 2007</i>	17b-277
Sec. 5	<i>July 1, 2007</i>	17b-289
Sec. 6	<i>July 1, 2007</i>	17b-292
Sec. 7	<i>July 1, 2007</i>	17b-295
Sec. 8	<i>July 1, 2007</i>	17b-297
Sec. 9	<i>July 1, 2007</i>	17b-297b(a)
Sec. 10	<i>July 1, 2007</i>	New section
Sec. 11	<i>from passage</i>	19a-88
Sec. 12	<i>July 1, 2007</i>	New section
Sec. 13	<i>July 1, 2007</i>	New section
Sec. 14	<i>July 1, 2007</i>	New section
Sec. 15	<i>July 1, 2007</i>	38a-482
Sec. 16	<i>July 1, 2007</i>	38a-497
Sec. 17	<i>July 1, 2007</i>	38a-554
Sec. 18	<i>July 1, 2007</i>	38a-564(19)
Sec. 19	<i>July 1, 2007</i>	38a-564(24)
Sec. 20	<i>July 1, 2007</i>	38a-565(b)
Sec. 21	<i>July 1, 2007</i>	38a-570
Sec. 22	<i>October 1, 2007</i>	38a-1041

Sec. 23	<i>October 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>October 1, 2007</i>	New section
Sec. 27	<i>October 1, 2007</i>	New section
Sec. 28	<i>October 1, 2007</i>	New section
Sec. 29	<i>from passage</i>	New section
Sec. 30	<i>from passage</i>	New section
Sec. 31	<i>from passage</i>	New section
Sec. 32	<i>from passage</i>	New section
Sec. 33	<i>July 1, 2007</i>	New section
Sec. 34	<i>July 1, 2007</i>	New section
Sec. 35	<i>July 1, 2007</i>	New section
Sec. 36	<i>July 1, 2007</i>	New section
Sec. 37	<i>July 1, 2007</i>	New section
Sec. 38	<i>July 1, 2008</i>	New section
Sec. 39	<i>July 1, 2008</i>	New section
Sec. 40	<i>July 1, 2008</i>	New section
Sec. 41	<i>July 1, 2007</i>	New section
Sec. 42	<i>July 1, 2007</i>	New section
Sec. 43	<i>July 1, 2007</i>	New section