House of Representatives

General Assembly

File No. 671

February Session, 2008

Substitute House Bill No. 5617

House of Representatives, April 17, 2008

The Committee on Appropriations reported through REP. MERRILL of the 54th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT MAKING REVISIONS TO THE CHARTER OAK HEALTH PLAN.

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

Section 1. Section 17b-311 of the 2008 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2008*):

(a) There is established the Charter Oak Health Plan for the purpose of providing access to health insurance coverage for uninsured state residents **[**who have been uninsured for at least six months and**]** who are ineligible for other publicly funded health insurance plans. The Commissioner of Social Services may enter into contracts for the provision of comprehensive health care for such uninsured state residents. The commissioner shall conduct outreach to facilitate enrollment in the plan.

(b) The commissioner shall impose cost-sharing requirements in connection with services provided under the Charter Oak Health Plan.

Such requirements may include, but not be limited to: (1) A monthly premium; (2) an annual deductible not to exceed one thousand dollars; (3) a coinsurance payment not to exceed twenty per cent after the deductible amount is met; (4) tiered copayments for prescription drugs determined by whether the drug is generic or brand name, formulary or nonformulary and whether purchased through mail order; (5) no fee for emergency visits to hospital emergency rooms; (6) a copayment not to exceed one hundred fifty dollars for nonemergency visits to hospital emergency rooms; and (7) a lifetime benefit not to exceed one million dollars.

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

(d) The Commissioner of Social Services shall determine minimum requirements on the amount, duration and scope of benefits under the Charter Oak Health Plan, except that there shall be no preexisting condition exclusion and the commissioner shall ensure that the plan includes comprehensive coverage for mental health services consistent with the provisions of section 38a-514. Each participating insurer shall

provide an internal grievance process by which an insured may request and be provided a review of a denial of coverage under the plan consistent with the provisions of section 38a-226c. An insured shall also have access to an external appeal process consistent with the provisions of section 38a-478n, and each participating insurer shall comply with the notification and other requirements of the external appeal process.

(e) The Commissioner of Social Services may contract with the following entities for the purposes of this section: (1) A health care center subject to the provisions of chapter 698a; (2) a consortium of federally qualified health centers and other community-based providers of health services which are funded by the state; or (3) other consortia of providers of health care services established for the purposes of this section. Providers of comprehensive health care services as described in subdivisions (2) and (3) of this subsection shall not be subject to the provisions of chapter 698a. Any such provider shall be certified by the commissioner to participate in the Charter Oak Health Plan in accordance with criteria established by the commissioner, including, but not limited to, minimum reserve fund requirements. Any entity entering into a contract pursuant to this subsection shall be licensed by the Insurance Department if required by any provision of the general statutes to be so licensed.

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

(g) (1) The State Comptroller shall contract with an independent actuary to perform: (A) No later than thirty days prior to the implementation of the Charter Oak Health Plan, an actuarial analysis of the feasibility and sustainability of the Charter Oak Health Plan under the proposed design; and (B) semiannual actuarial analyses of

the feasibility and sustainability of the Charter Oak Health Plan.

(2) The independent actuary hired pursuant to subdivision (1) of this subsection shall report the findings of the analyses conducted pursuant to subdivision (1) of this subsection and make recommendations on the plan, design, pricing and sustainability of the Charter Oak Health Plan to the joint standing committee of the General Assembly having cognizance of matters relating to human services and to the Department of Social Services.

(h) The Commissioner of Social Services shall submit monthly reports to the advisory council on Medicaid managed care, established pursuant to section 17b-28, on the Charter Oak Health Plan and its implementation, including, but not limited to, information on costs and utilization of care.

(i) Each entity participating in the Charter Oak Health Plan pursuant to subsection (e) of this section shall report no less than quarterly to the joint standing committee of the General Assembly having cognizance of matters relating to human services and to the Department of Social Services, the following information: (1) Member enrollment for each month of the quarter; (2) utilization of services by service category, individual members and age cohorts; and (3) financial data on expenditures, including, but not limited to, subcontractor capitation payments and subcontractor medical expenses by service category.

[(g)**]** (j) The Commissioner of Social Services, pursuant to section 17b-10, may implement policies and procedures to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of the intent to adopt the regulation in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policies shall be valid until the time final regulations are adopted and may include **[**: (1) Exceptions to the requirement that a resident be uninsured for at least six months to be eligible for the Charter Oak Health Plan; and (2)**]** requirements for open enrollment and limitations

on the ability of enrollees to change plans between such open enrollment periods.

Sec. 2. Section 38a-479aa of the 2008 supplement to the general statutes is amended by adding subsection (n) as follows (*Effective July 1, 2008*):

(NEW) (n) The requirements of subsections (h) and (i) of this section shall not apply to a consortium of federally qualified health centers funded by the state providing services only to recipients of programs administered by the Department of Social Services. Any such provider shall be certified by the Commissioner of Social Services in accordance with criteria established by the commissioner, including, but not limited to, minimum reserve fund requirements.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2008*	17b-311
Sec. 2	*July 1, 2008*	38a-479aa

HS *Joint Favorable Subst. C/R* APP

APP *Joint Favorable*

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

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 09 $	FY 10 $
Department of Social Services	GF - Cost	Indeterminate	Indeterminate
Comptroller	GF - Cost	150,000	150,000

Municipal Impact: None

Explanation

The bill eliminates the requirement that an enrollee has been uninsured for at least 6 months. This provision would likely increase enrollment in the Charter Oak Plan. To the extent that these increases occur in the state subsidized portion of the program, additional state costs would result.

The bill also requires that comprehensive mental health services be included in the Charter Oak Plan. The bill also requires contractors under the Charter Oak Plan to provide access to an external appeals process. These changes would likely increase the overall costs of the program. Should the state still maintain a maximum monthly premium of $250, these increased program costs will be borne by the state. Without actuarial analysis, the extent of these increased costs cannot be estimated.

The bill further requires DSS to report monthly to the General Assembly on Charter Oak implementation. The department would incur a minimal administrative cost from this reporting requirement.

The bill requires the Comptroller to contract with an actuary to analyze the feasibility and sustainability of the Charter Oak Health Plan under the proposed design. It is anticipated this would require $150,000 to undertake. No funds are provided in sHB 5021 (the budget

bill, as favorably reported by the Appropriations Committee) for this actuarial analysis.

Finally, this bill exempts a consortium of federally qualified health centers that provides services only to the Department of Social Services from certain minimum reserve requirements. As this bill conforms statute to the recent operational interpretation, there is no fiscal impact.

It should be noted that the Charter Oak Plan has not yet been implemented. As such, the Office of Fiscal Analysis has no data on the cost of the program or on the enrollment. The analysis above is based on the program model and data assumptions contained in the Governors FY09 budget revisions. The Governor's model assumes that 19,200 individuals will be enrolled in the program in the first year of operation. Of these, 13,700 are expected to be state subsidized.

The Out Years

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

OLR Bill Analysis

sHB 5617

AN ACT MAKING REVISIONS TO THE CHARTER OAK HEALTH PLAN.

SUMMARY:

This bill makes several changes in the law governing the Charter Oak Health Plan (COHP), a health insurance program established in 2007 and scheduled to be operational on July 1, 2008. Specifically, it:

1. eliminates the minimum amount of time that program participants must be uninsured to qualify ("crowd-out"),
2. requires COHP to include comprehensive mental health coverage that is consistent with the state's mental health parity law as it applies to group health insurance plans,
3. requires any insurer that participates in COHP to have internal and external appeals processes that are consistent with the state's insurance laws,
4. requires the entities authorized to participate in COHP to be licensed by the Insurance Department if any state law requires the licensure,
5. exempts certain preferred provider networks from the law's minimum reserve requirements,
6. requires the state comptroller to contract with an independent actuary to determine COHP's feasibility and sustainability, and
7. requires reports on COHP's implementation.

The bill makes a technical, conforming change.

EFFECTIVE DATE: July 1, 2008

ELIMINATION OF CROWD OUT

The bill eliminates the requirement that an individual be uninsured for at least six months before he or she can qualify for COHP benefits. It retains the requirement that the individual is uninsured and ineligible for "other publicly funded" health insurance plans (e.g., Medicaid).

MENTAL HEALTH PARITY

The bill requires the Department of Social Services (DSS) commissioner to ensure that the plan includes comprehensive mental health coverage, which must be consistent with the state's mental health parity law as it pertains to group health insurance plans.

Under the parity law, no group insurance policy can establish any terms, conditions, or benefits that place a greater financial burden on an insured person for accessing services to diagnose or treat "mental or nervous" conditions than it would for medical, surgical, or other physical health conditions (see BACKGROUND).

APPEALS

By law, each insurer that participates in COHP must provide an internal grievance process that plan members can use when they have been denied coverage. By law, the person denied coverage can request, and the insurer must provide, a review of the coverage denial. The bill requires this process to be consistent with the law governing utilization review companies, which includes notification standards and time frames (see BACKGROUND).

The bill also requires COHP to have an external appeals process that is consistent with the process prescribed in the managed care law. That law allows an enrollee in a managed care plan who has exhausted the plan's internal review process to appeal to the insurance commissioner any denial of a claim, either based on medical necessity or a determination not to certify an admission, services, procedure, or extension of stay. An enrollee must file an external appeal within 60

days of receiving a final denial.

The bill requires the COHP insurer to comply with the law's notification and other requirements of the external appeals process (see BACKGROUND).

LICENSURE REQUIRED; RESERVE FUND EXEMPTION

The law permits the DSS commissioner to contract with HMOs, a consortium of federally qualified health centers (FQHC), other community-based health care providers that are state-funded, or other consortia of health care providers to provide services to COHP enrollees. The commissioner must certify them to participate in the plan, in accordance with any criteria he establishes, including minimum reserve fund requirements. The bill requires these entities to have an Insurance Department license if any state law requires such.

The bill specifies that the law governing preferred provider networks that requires the networks to (1) have a minimum net worth and (2) maintain a reserve fund used exclusively to pay any outstanding amounts due to providers does not apply to a state-funded FQHC consortium that provides services only to recipients of programs that DSS administers (see BACKGROUND). (DSS currently administers the State Administered General Assistance (SAGA) program through a contract with an FQHC consortium.)

COMPTROLLER—ACTUARIAL ANALYSES OF CHARTER OAK

The bill requires the comptroller to contract with an independent actuary to analyze the feasibility and sustainability of the COHP. The initial analysis must be completed no later than 30 days before the plan is implemented and semiannually thereafter.

REPORTS

The bill requires the actuary to report his or her findings and make recommendations related to COHP's design, pricing, and sustainability, to the Human Services Committee and DSS.

The bill also requires DSS to submit monthly reports to the

Medicaid Managed Care Council on COHP and its implementation, which must include information on costs and care utilization.

And it requires each participating health care entity to report the following to the Human Services Committee and DSS at least quarterly: (1) member enrollment for each month in the quarter; (2) service utilization by category, individual members, and age cohorts; and (3) financial data on expenditures, which must include, at a minimum, subcontractor capitation payments and medical expenses by service category.

BACKGROUND

COHP

PA 07-2, June Special Session, established COHP, and permitted DSS to enter into contracts to provide comprehensive health care for the uninsured. The act allows DSS to charge cost sharing, as well as establish a $1 million lifetime benefit. And it provides premium assistance for individuals with incomes less than 300% of the federal poverty level (currently $52,800 for a family of three).

The commissioner must determine minimum requirements for COHP benefits' amount, duration, and scope, which cannot include a pre-existing condition exclusion. It is effective on July 1, 2008.

DSS issued a request for proposals earlier this year.

Mental Health Parity (CGS § 38a-514)

The law defines "mental or nervous conditions" as mental disorders, as used in the American Psychiatric Association's most recent *Diagnostic and Statistical Manual of Mental Disorders,* DSM-IV-TR (fourth edition, text revision). It specifically excludes (1) mental retardation; (2) learning, motor skills, communication, and caffeine-related disorders; (3) relational problems; and (4) additional conditions not otherwise defined as mental disorders in the DSM-IV-TR.

The law permits, based on certain conditions, coverage for services provided by psychologists, social workers, marital and family

therapists, alcohol and drug counselors, and residential treatment facilities.

Utilization Review Companies-Internal Appeals (CGS § 38a-266c)

The law establishes minimum standards for companies that perform utilization review on behalf of insurers. For example, it requires the companies to notify providers and enrollees, in writing, within two business days of receiving all of the information necessary to complete their review. It requires determinations not to certify admissions, services, procedures, or extended stays to include, in writing, the principal reasons for the denial, and the procedures to initiate an internal appeal and an appeal to the insurance commissioner. And it requires final determinations to include, in writing, the principal reasons for the denial, a statement that all internal appeal mechanisms have been exhausted, and a copy of the application and procedures for filing appeals with the insurance commissioner.

External Appeals (CGS § 38a-478n)

The law gives enrollees who have exhausted the internal appeals process provided by managed care plans, insurers, or preferred provider utilization review companies the right to appeal to the insurance commissioner. They must file a written request no later than 60 days after receiving the denial notice, and pay a $25 filing fee, which is refunded if they win their appeal. And it prescribes timeframes for responding to requests for information from the commissioner. The commissioner assigns the appeals to a review entity.

Preferred Provider Network (PPN) Minimum Reserve Requirements (CGS § 38a-479aa)

Preferred provider networks (PPNs), which are not managed care organizations, (1) pay claims for health care service delivery; (2) accept financial risk for the delivery; and (3) establish, operate, or maintain arrangements or contracts with providers. They are subject to Insurance Department regulation. By law, each PPN must maintain a minimum net worth of either (1) the greater of $250,000 or 8% of annual expenditures or (2) an amount the insurance commissioner

prescribes. In addition, they must maintain or arrange for a letter of credit, bond, surety, reinsurance, reserve, or other financial security that the commissioner approves for the exclusive use of paying any outstanding amounts owed participating providers in the event of insolvency or nonpayment. At a minimum, this must be the greater of (1) an amount sufficient to pay providers for two months, (2) the actual outstanding amount owed providers, or (3) an amount the commissioner determines. This amount can be credited against the minimum net worth requirement.

Related Bill

sHB 5618 (File 338), reported by the Human Services Committee, mandates that any contracts that DSS enters into to purchase insurance for Medicaid and HUSKY recipients be separate and independent from any contract for providing health care services under COHP.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute Change of Reference
Yea 13 Nay 5 (03/18/2008)

Appropriations Committee

Joint Favorable
Yea 35 Nay 17 (03/28/2008)