



Testimony Before the Human Services Committee

LEGISLATION INTRODUCED AT THE REQUEST OF GOVERNOR RELL

- S. B. No. 32 AN ACT CONCERNING THE FINANCIAL CONDITION OF NURSING HOMES.
- S. B. No. 33 AN ACT IMPLEMENTING THE GOVERNOR'S RECOMMENDATIONS WITH RESPECT TO SOCIAL SERVICES PHARMACY PROGRAMS.
- S. B. No. 34 AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS WITH RESPECT TO SOCIAL SERVICES PROGRAMS.

TESTIMONY IN OPPOSITION TO:

- H. B. No. 5617 (RAISED) AN ACT DELAYING IMPLEMENTATION OF AND MAKING REVISIONS TO THE CHARTER OAK HEALTH PLAN.

OTHER LEGISLATION CONCERNING THE DEPARTMENT OF SOCIAL SERVICES:

- S. B. No. 415 (RAISED) AN ACT CONCERNING APPROPRIATIONS FOR THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM AND GRANTS FOR EMERGENCY AND COMMUNITY FOOD SITES.
- Proposed H. B. No. 5072 AN ACT CONCERNING APPROPRIATIONS TO IMPROVE NURSE STAFFING RATIOS.
- H. B. No. 5618 (RAISED) AN ACT CONCERNING REVISIONS TO THE HUSKY PLAN.
- H. B. No. 5620 (RAISED) AN ACT RAISING THE CHILD SUPPORT AGE LIMIT.

Michael P. Starkowski
Commissioner
 February 26, 2008

Testimony

Good morning, Senator Harris, Representative Villano and members of the Human Services Committee. My name is Michael P. Starkowski. I am the Commissioner of the Connecticut Department of Social Services (DSS). I am principally here this morning to testify in support of legislation introduced in the committee at the request of Governor Rell. This legislation is needed to implement a range of provisions contained in the Governor's SFY 2009 Midterm Budget Adjustment Recommendation concerning the programs, services and operations of DSS. I also have written comments for the record on several other bills on today's public hearing agenda. Specifically, I will be offering testimony in strong opposition to legislation that would delay and diminish the effectiveness of the developing Charter Oak Health Plan. I would like to begin with the legislation recommended by the Governor.

Governor's Recommended Legislation

S. B. No. 32 AN ACT CONCERNING THE FINANCIAL CONDITION OF NURSING HOMES.

This bill implements the Governor's nursing facility oversight initiative. It will enable the Department to increase financial oversight of the state's 241 skilled nursing facilities by providing additional authority to monitor changing economic conditions. The goal is to better identify and root out the type of fiscal deterioration that led to the unprecedented bankruptcy filing of 15 Connecticut facilities owned by Haven Healthcare Inc. in November.

This initiative will strengthen financial oversight at five critical levels that affect the viability of nursing homes:

- ownership changes;
- high indebtedness;
- timely identification of unpaid bills to vendors and other ongoing financial factors;
- split real estate and operational ownership; and
- unreasonable rent payments.

Both the Connecticut Medicaid program, administered by DSS, and the federal Medicare program conduct audits of nursing homes. However, these audits are focused on "allowable costs" for rate-setting and reimbursement for the care of Medicaid and Medicare beneficiaries. While Connecticut has a number of significant limitations on allowable costs recognized by the Medicaid rate, there is no comprehensive review of a nursing home owner's entire book of business (revenue and expenditures). This means that the whole picture of an individual or chain owner is not analyzed. Currently, in Connecticut and most other states, there is essentially no formal financial oversight of the operations responsible for caring for our most frail and needy elders and people with disabilities.

Governor Rell's nursing home financial oversight reform package includes the following areas:

1. Addressing Financial Issues When There is a Change of Ownership

Although there is presently a moratorium on licensing new long term care facilities, approval by the Department of Social Services of a change in ownership of a long-term care facility is only required for a newly licensed facility. The Governor will introduce statutory changes that will require approval by DSS of any full or partial transfer of ownership or control of a long-term care facility, whether at initial licensure if the moratorium is lifted or during the operating life of the facility. The approval process will include a review of the financial feasibility of the change, any per-diem rate impact caused by the change and the applicant's fiscal condition. This additional review and approval process will guard against the ownership of facilities by companies not financially capable of maintaining the service/facility on a long-term basis.

2. Addressing Issues of Split Real Estate and Operational Ownership

Presently, some owners of the nursing home real estate do not own the company licensed to operate the facility. This is the case with many of the facilities operated by national nursing home chains. The buildings are often owned by real estate investment trusts. Split ownership significantly complicates the sale of troubled facilities, receivership and enforcement actions. A proposed statutory change would require that all future ownership of homes be restricted to a single entity which must own the business, real estate and be the licensee of the facility. Existing facilities would be grandfathered in and the department would establish an exception process for situations where the health and safety of residents may be in jeopardy.

3. Addressing High Indebtedness

High borrowing by facilities has contributed to a number of facility failures. A statutory change would be instituted requiring nursing facilities to seek approval of the Commissioner of Social Services to increase the indebtedness of either the nursing home company operating the home or the company that owns the property. Thresholds would be established so that routine borrowing needs would not require state approval. The thresholds would be established after discussions with the Department of Banking on reasonableness of the indebtedness of the home. Procedures will be established to insure prompt review of these interest sensitive transactions.

4. Addressing Indicators of Financial Problems

The Governor will require DSS to establish clear and uniform criteria to identify when a facility's financial status is marginal or if a facility is having severe financial

difficulties. These criteria will assist the department in reviewing financial information submitted by nursing facilities to help determine if they have sufficient resources to meet operational and financial expenses and to comply with resident care and facility standards. The criteria will coincide with additional requirements on nursing facilities to submit information (see #5 below).

The criteria shall include, but not be limited to:

- Frequency of Medicaid advances granted in accordance with PA 7-01 JSS;
- Unfavorable working capital ratios of assets to liabilities;
- High proportion of accounts receivable and/or accounts payable more than 90 days old;
- Significant increases in accounts payable, unpaid state or municipal taxes, state user fees, and/or payroll-related costs;
- Minimal equity and/or reserves or decreasing equity and/or reserves
- High levels of debt and high borrowing costs.
- Significant increases in debt and borrowing costs; and
- Significant operating losses for 2 or more consecutive years

5. Addressing the Need for Timely Identification of Financial Problems

Presently, nursing home financial information such as expenditures, revenue and balance sheet data is submitted annually to the Department of Social Services for per diem rate-setting purposes (rate-setting refers to the amount of Medicaid funding to be granted per beneficiary/per day, based on a federally-approved methodology of allowed costs).

This information is audited by DSS to determine the legitimacy of the per diem rate request submitted by the facility and determined by the department. This information is not used to determine the financial viability of the facility.

The Governor is proposing legislation that would provide authority to DSS to require facilities to provide additional financial information, including but not limited to:

- annual audited financial statements;
- debt agreements;
- accounts payable aging reports; and
- financial statements for parent companies that own multiple nursing facilities.

This information will be used by DSS to closely monitor the financial viability of nursing facilities on an ongoing basis; essentially, this will create a 'tripwire' alert when, for example, a nursing facility falls behind on paying its bills.

6. Addressing Unreasonable Rent Payments Under Receivership

While owners under are allowed reimbursement for their property costs, this is

capped by DSS as maximum fair rent. When a facility is under receivership, the receiver has to apply to and receive approval from the court for the payment of rent to the owner. At the present time, there are no financial limitations on the amount of rent reimbursement for the owner the receiver may request from the court. With no limitations, these payments could be set at an amount far in excess of property reimbursement amounts allowed under Medicaid. A revision to the receivership statute is being proposed so that property costs set by the courts will not exceed the fair rental value allowance set by Medicaid.

The Governor's recommendation funds 5 additional staff at DSS to help with implementation of this comprehensive financial oversight initiative.

We understand there are several other nursing home oversight proposals before the state legislature this session. While I believe the Governor offers the most comprehensive approach, I would be happy to work with the Human Services Committee on any of the initiatives currently before the committee.

S. B. No. 33 AN ACT IMPLEMENTING THE GOVERNOR'S RECOMMENDATIONS WITH RESPECT TO SOCIAL SERVICES PHARMACY PROGRAMS.

This legislation expands our pharmaceutical manufacturers rebates to the State of Connecticut for any pharmaceutical paid for in any of the Department's medical assistance programs, including Medicaid fee-for-service; Medicare Part D non-formulary drugs paid by the Department; SAGA, ConnPACE, and HUSKY. Adoption of this bill will result in a significant savings to the state as rebates collected average approximately 18-22%.

Currently the Department collects rebates only for Medicaid fee-for-service (under the federal rebate program) and ConnPACE (under a separate individual manufacturer rebate contract). The Department is not able to collect rebate for Medicaid Part D non-formulary drugs paid for by the Department for our clients who are both eligible for Medicare and Medicaid.

I am asking the Committee to report this legislation favorably to the Senate Floor as soon as possible so that the enhanced rebates can be experienced at the earliest possible time.

S. B. No. 34 AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS WITH RESPECT TO SOCIAL SERVICES PROGRAMS.

Funding for Interpreter Services (Section 1)

The Governor's Recommended Budget proposes to eliminate \$4.7 million in funding for interpreter services. The original SFY 2008 - 2009 budget included funding of \$1.175

million in SFY 2008 and we are not recommending any additional commitments at this time. This service would provide translation services to DSS Medicaid fee-for-service clients in all hospitals and doctor's offices across the state. In addition to internal discussions over the procedural aspects of implementing a program that could entail over 6000 providers in the state, staff in the department have had numerous discussions with representatives of the Statewide Interpreters Association to determine the most cost effective and efficient approach. As you may be aware in recent years technologies has provided the ability to have interpreter services implemented offsite through the use of professionally staffed telephone services for simultaneous translations. Currently these services are in use at DSS and many community health centers. The department will continue to pursue these services with the intent of requesting carry forward authorization into SFY 09.

Medical Necessity and Appropriateness Definition under Medicaid (Section 2)

The Governor's Recommended Budget includes a reduction of \$4.5 million in SFY 2009 to reflect the proposal to allow the Department of Social Services to update the current medical necessity definition under Medicaid. The Department would replace current medical necessity and appropriateness definitions with the definition currently utilized within the SAGA medical program since January 2005. This will mirror commercial and Medicare definition criteria.

The medical necessity definitions utilized within the various state medical assistance programs should be an integrated concept. Currently, the medical necessity definition under Medicaid fails to provide for the application of medical evidence in medical review decisions and it establishes an unreasonably high standard of services necessary to achieve "optimal" functioning. The proposal suggests using the definition employed by Medicare and private commercial health care plans, which incorporates providing services that are "reasonable and necessary" in light of clinical standards of practice. This updated medical necessity definition would combine the concepts of medical necessity and appropriateness under a single definition as is done in Medicare and under most public sector and commercial health care programs, and it would revise the department's definition to allow for evidenced based medical necessity decisions.

Limit Rate Increases for Residential Care Homes (RCH) (Section 3)

The Governor is proposing to limit rate increases to RCHs up to 2%. This bill implements this proposal. While this imposes a cap to the rates, it does allow for a 2% rate increase for the RCHs, except where a facility would have been issued a lower rate effective July 1, 2008, due to interim rate status or there was an agreement with DSS for a lower rate effective July 1, 2008. The uncapped rate increases in SFY 2008 are contributing to a deficiency in the Aid to the Aged, Blind and Disabled (AABD) program. This will bring funding more in line with the original SFY 2009 appropriation.

Require Certification for Medication Administration in Residential Care Homes and Boarding Homes (Section 4)

The Governor proposes that Residential Care Homes and Boarding Homes be required to have individual employees certified to provide medication administration to their residents. This will result in a savings to Medicaid, while funds have been allotted to the Aid to the Aged, Blind and Disabled programs to cover this increased requirement. Nurses will still be required to administer injections, except where there is an injectable medication in a pre-measured, commercially prepared syringe to a resident with a diagnosed medical condition who may require emergency treatment. This will result in a net savings of \$1,445,903. This provision is needed to implement this recommendation.

Child Support Disregard (Section 5)

Section 5 of the bill amends the statutes to provide for a \$100 child support disregard, an increase from the current \$50 level. The federal Deficit Reduction Act of 2005 provides for the federal government to participate in state disregard of child support when calculating eligibility and benefits under the Temporary Assistance for Needy Families Program. With this change the state is no longer required to reimburse the federal government for its share of the disregarded child support. The Governor is recommending that we pass the resulting windfall on to the recipients of Temporary Family Assistance by increasing the amount of child support disregarded when determining eligibility for that program. This restores the disregard to the level in effect under the state's original welfare reform program and will create a greater incentive for TFA parents to cooperate in establishing child support orders as well as providing additional income to these families to help stabilize their basic need circumstances.

We are asking the Committee to revised the effective date of this section from July 1, 2008 to October 1, 2008 conform this provision with the effective date of the new federal rule.

Hospice Initiative (Section 6)

The Governor's Recommended Budget includes a proposal to amend the Medicaid state plan to include hospice benefits no later than February 1, 2009. Any additional costs of providing hospice services in home and community settings are expected to be offset by reductions in end-of-life inpatient and other institutional care. The recommended legislation directs DSS to work with OPM in evaluating the cost effectiveness of this approach and moving forward with a state plan amendment these provisions are found to be cost effective.

Hospice services involve a team-oriented approach of expert medical care, pain management, and emotional/spiritual support to meet the patient's wishes. It is geared toward helping avoid placement in an institutional setting, ultimately improving the quality of life for the individual as well as the family. Hospice care for the terminally ill

has been covered by Medicare since 1982. In 1985, Medicaid coverage for hospice care became an optional benefit, which Connecticut did not elect to implement. As of January 2008, Connecticut was one of only two states that did not have specific Medicaid state plan hospice coverage.

Some services Connecticut may cover include: terminally ill residents of nursing homes who are under age 65; social workers, respite care, or bereavement counseling for terminally ill patients. As the population ages, hospice care is expected to grow.

Behavioral Health Partnership and Oversight Council (Sections 7 and 8).

The Court Support Services Division (CSSD) of the Judicial Branch current provides grant funded behavioral health services to court involved children who are not otherwise eligible for HUSKY or the Connecticut Behavioral Health Partnership (BHP). The proposed legislation would enable DSS and DCF to enroll non-HUSKY children involved with CSSD in the BHP for limited home-based services. This in turn would allow CSSD to reduce or eliminate grants for these same services and it would allow for the use of the BHP infrastructure to manage these services. CSSD would also be provided with a seat on the BHP Oversight Council. The three agencies proposed this language in a budget option and this initiative is supported in the Governor's budget. The fiscal impact primarily resides with CSSD which would be responsible for the service costs of CSSD children served under the BHP.

The Governor's budget continues to support the BHP, which is a joint program administered by the Departments of Social Services and Children and Families. The BHP offers integrated behavioral health services to HUSKY A and HUSKY B members, and to children with complex behavioral needs served by DCF. The BHP promotes access to and coordination of community-based behavioral health services, better management of State resources, and increased Medicaid revenue. The Governor's proposed budget supports a continuation of the program's growth and success, increasing funding to \$127 million in SFY 2009.

Allow Special Needs Trusts under the Aid to the Aged, Blind and Disabled (AABD) Program for Certain Boarding Home Residents (Section 9)

This section of the bill provides for a change to the State Supplement program to permit residents of residential care homes and New Horizons Village to transfer the portion of their income that exceeds the gross income limit for that program into a special needs trust. By doing so the income will not be countable and the resident may continue to qualify for the State Supplement program.

Currently if a resident of one of these facilities has income above the State Supplement income limit and applies for benefits after spending down their assets as a private pay resident, or has an increase in income that causes their income to exceed this limit, the

department must deny or discontinue assistance, even though the resident's income is not sufficient to pay for their care. Such individuals typically must relocate to a more restrictive and expensive facility, which can be reimbursed under the Medicaid program's medically needy coverage, which does not use this special income limit. Not only does this disrupt the life of the elderly or disabled individual, it also can result in additional costs to the state, as the Medicaid facility rate will be higher than the cost of allowing the individual to remain at the residential care home or New Horizons. With this change we can assure that the recipient can continue to reside in the least restrictive setting with the least cost to the State of Connecticut.

Finally, please find attached to our written testimony a revision in the proposed language to more explicitly state that the portion of the applicant's or recipient's income that is deposited into the special needs trust will not be countable toward the State Supplement gross income limit.

H. B. No. 5617 (RAISED) AN ACT DELAYING IMPLEMENTATION OF AND MAKING REVISIONS TO THE CHARTER OAK HEALTH PLAN.

I also want to voice my strong opposition to this legislation. As a practical matter, HB No. 5617 would permanently dismantle Charter Oak under the guise of an implementation delay with enriched benefits that would effectively prevent its implementation due to increased cost to enrollees and taxpayers. Charter Oak, from its inception, was carefully crafted to balance the costs to the individual and the costs to the state.

These changes would completely and permanently derail the implementation because they would alter the fundamental structure, which made Charter Oak an affordable health coverage program.

Specifically, the legislation:

- Reduces the annual deductible from a maximum of \$9000 to \$100
- Eliminates any coinsurance requirement
- Reduces the copayment for misuse of emergency rooms from \$100 to \$20
- Eliminates \$1 million lifetime benefit
- Eliminates the \$7,500 annual limitation on pharmacy (this had already been increased by DSS from \$2,500 to \$7,500, based on legislative and advocacy concerns)
- Eliminates the \$4,000 annual limitation on durable medical equipment (this too had already been increased by DSS from \$2,000 to \$4,000, based on legislative and advocacy concerns)
- Adds dental services as a mandated benefit
- Adds vision care as a mandated benefit
- Mandates mental health parity
- Eliminates the six-month requirement for being uninsured.

Moreover, the bill removes all of the flexibility the state has to negotiate any flexibility in the benefit package. With these changes, it is inconceivable that the Charter Oak monthly premium could remain under \$250 without an enormous government subsidy. This is altogether counter to the premise of Charter Oak.

As DSS tries to guarantee continuity of services for HUSKY and Charter Oak enrollees with the same set of health insurers and with the same set of healthcare providers; and as DSS tries to achieve efficiencies through a combined bidding /contracting process, this bill would specifically prohibit these practices which will benefit the state and, most of all, the vulnerable children and adults we are here to serve.

While we respect the Legislature's right to review and revise programs, we also believe that Connecticut adults need affordable health coverage, and they need it in 2008. The problem with Raised Bill No. 5617 (besides needless delay) is that Charter Oak will probably *never* happen if the program cost to the State of Connecticut is too high. We saw this last year at the legislature -- a proposal for expensive, universal health care failed because of the high price tag. As approved by the Legislature in 2007, Charter Oak is a good, workable plan.

Charter Oak offers hope for a great many of our citizens. I urge the committee to reject this legislation.

In summary, Raised Bill No. 5617:

- Would not only delay the Charter Oak Health Plan for another year, it would effectively prevent it happening at all.
- It completely disrupts the program and needlessly hurts the uninsured adults in Connecticut who are waiting anxiously for their chance for affordable coverage beginning on July 1, 2008.
- The delay called for by the bill is bad enough – and the other specific provisions in the bill would make Charter Oak unaffordable for both consumers and taxpayers.
- It would also overturn the program as legislated last session (including the July 1, 2008, start date).
- Governor Rell, the Office of Policy and Management, the Department of Social Services, the Department of Public Health and the Office of Healthcare Access strongly oppose the bill, on behalf of Connecticut's uninsured adults who are waiting for Charter Oak to help them access health coverage.
- Raised Bill No. 5617 is extremely detrimental to the thousands of uninsured adults in Connecticut who could benefit from the Charter Oak Health Plan in July.

Together, Raised Bill No. 5617 and the anti-joint procurement portion of Raised Bill No. 5618 (testimony below) represent a giant step backward when Connecticut is on the verge of great progress in covering our uninsured adults – while planning to streamline

this new coverage with our existing, highly successful HUSKY program for children and low-income parents.

Other Legislation Related to DSS

Proposed H. B. No. 5072 AN ACT CONCERNING APPROPRIATIONS TO IMPROVE NURSE STAFFING RATIOS.

This bill would appropriate an unspecified amount in SFY 2009 to improve nursing home staffing ratios. In addition, it requires that future rate increases be targeted to staffing increases and resident care.

Current Department of Public Health regulations specify minimum nurse and nurse aide staffing for day, evening and night periods. These requirements equate to about 2 hours per day per resident for Chronic and Convalescent Nursing Home (CCNH) licensed facilities and .90 hours (54 minutes) per day per resident for Rest Home with Nursing Supervision (RHNS) licensed facilities. Of the 29,136 licensed nursing facility beds in the state, only 901 are licensed under the RHNS category.

Current minimum staffing standards in Connecticut over a twenty-four hour period equate to an average of one nurse per 40 residents (1:40) and one nurse aide per 20 residents (1:20) for total direct care ratio of one to thirteen residents (1:13). The Federal minimum requirement is below the state standard but the Centers for Medicare and Medicaid Services (CMS) has published recommended levels that equate to daily averages of 1:29 for nursing and 1:14.6 for nurse aides (Total direct ratio of 1:10). The National Citizens Coalition for Nursing Home Reform recommended levels equate to a direct care total of 1:7 (1:25 nurses and 1:10 nurse aides).

If funding is provided as proposed under this bill, it is expected that the Department would work closely with the Department of Public Health (DPH) to develop an application or distribution method for Medicaid rate add-ons for direct care staffing increases. The Medicaid rate adjustment method would need to be submitted to and approved by CMS in the form of a Medicaid State Plan amendment in order to obtain 50% federal reimbursement.

We would seek DPH assistance to obtain and review facility specific acuity/case mix data from resident assessment information for Medicaid residents that is regularly reported to DPH by nursing homes per Federal requirements. Acuity/case mix data could be used to develop estimated direct care staffing requirements for each facility. Estimated staff needs would be compared to nurse and nurse aide hour information provided in annual Medicaid cost reports to identify those facilities that may have lower staff levels than projected in staffing models. Those facilities staffed below projected needs would likely be targeted for Medicaid rate add-ons under the method to be developed by the Department and DPH.

Targeting all future rate increases to direct care staffing is not advisable as facilities may face cost increases in other areas including heating oil, utilities and health insurance.

S. B. No. 415 (RAISED) AN ACT CONCERNING APPROPRIATIONS FOR THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM AND GRANTS FOR EMERGENCY AND COMMUNITY FOOD SITES.

This bill would increase funding for the Supplemental Nutrition Assistance Program (SNAP) by \$2 million and would also provide an additional \$2 million in funding for administration of food commodity programs by the Connecticut Food Bank and Food Share. Currently SNAP is funded at a level of \$446,829. Thus this represents a major increase in funding for the program as well as the administrative costs associated with storing and distributing food commodities. The department must oppose this bill as this funding is not included in the adopted or recommended budget adjustment.

H. B. No. 5618 (RAISED) AN ACT CONCERNING REVISIONS TO THE HUSKY PLAN.

H. B. No. 5618 (RAISED) AN ACT CONCERNING REVISIONS TO THE HUSKY PLAN.

This change would restore continuous eligibility for HUSKY A and B which was eliminated in 2003. Continuous eligibility guarantees eligibility for children under 19 for a full 12-month period even if there is a change in the family's circumstances which would otherwise render them ineligible.

For most families the continuous eligibility period is their 12-month renewal period and thus continuous eligibility will not benefit these families. However, it will benefit some families if the renewal period changes due to late processing of their redetermination or if the family's eligibility is discontinued for a reason other than not complying with redetermination requirements. A common example would be family that reports new or increased earnings resulting in their income exceeding 185% of the federal poverty level. Such a family will receive twelve months of transitional HUSKY A coverage and at the end of that twelve month extension they would receive additional months of continuous eligibility coverage. This will result in additional costs to the program that are not contemplated in the Governor's budget and thus the Department must oppose this provision.

Related to the elimination of HUSKY B cost-sharing requirements, it should be noted that the Federal government is going in the opposite direction. The Centers for Medicare and Medicaid Services (CMS) recently sent a letter that addresses a longer crowd-out period if we want to cover children above 200% of the FPL, but CMS also wants reassurance and documentation that cost sharing under the state's SCHIP program (HUSKY B) is not more favorable than competing private plans by more than 1% of family income. If we want to cover children above 250% FPL, we would need to

demonstrate to CMS that HUSKY B families are not spending less than one percentage point difference of their income in HUSKY B cost sharing than is being spent by families with private (commercial) insurance. For example if the average Connecticut family spends 6% of its family income for health insurance cost sharing, HUSKY B families can't be spending less than 5% of their family income on HUSKY B cost-sharing. If cost sharing is eliminated we would be out of compliance with Federal requirements.

Further, the eliminates a requirement that HUSKY enrollees with employer-sponsored insurance take advantage of that insurance, with HUSKY providing any wrap-around coverage to ensure no loss of benefits at a cost of \$4.9 million.

Additionally, Raised Bill No. 5618:

- Would delay HUSKY re-procurement another year.
- This would limit choices of health plans of more than 320,000 HUSKY beneficiaries.
- It would needlessly eliminate the state's ability to jointly procure HUSKY and Charter Oak. Why is joint procurement important?
 - Helps the insurers achieve economies of scale with automated systems, enrollment processes, etc.; and, by extension, potential savings for the State of CT.
 - Helps enrolled families by enabling 'one-stop shopping' for health coverage for children AND adults (same insurers and same doctors spanning across children's coverage, HUSKY A parental coverage, and – now--non-HUSKY adult coverage in Charter Oak).
 - Helps insurers with the new Charter Oak program by providing complementary bidding opportunity with HUSKY. This because HUSKY's known actuarial and utilization data will help offset the actuarial assumptions (rather than HUSKY's hard-core experiential data) of the brand-new Charter Oak program.
 - In short, joint procurement offers the promise of additional participating health plans, ease and convenience for enrolled families, and potential savings for the state as insurers achieve economies of scale.

H. B. No. 5620 (RAISED) AN ACT RAISING THE CHILD SUPPORT AGE LIMIT.

The Child Support Program is neutral regarding the policy of increasing the age limit for support to twenty-one years. However, there is a concern regarding fiscal impact, and several additional concerns over ambiguity and potential conflict in the bill language.

There will be a fiscal impact on the Child Support Program if support liability is increased to age twenty-one. Since the bill is worded to permit establishment of support up to the age of twenty-one, and not just continuation of support to such age after issuance of court-ordered support, there will be an additional workload on investigators in the Bureau of Child Support Enforcement (BCSE) within the department. BCSE is the lead IV-D agency for the State of Connecticut, and charged with establishment of

DSS Recommended Revision to Section 9 of SB No. 34

On line 377, after the word “section.” add: “Any of the individual’s excess available income that is transferred to a trust, as provided in this section, shall be excluded from consideration when determining the amount of income countable toward the program’s gross income limit.”