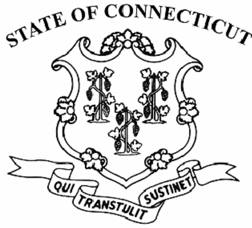

General Assembly **_Substitute Bill No. 5617_**

**February Session, 2008** *_____HB05617APP___040108____*

AN ACT MAKING REVISIONS TO THE CHARTER OAK HEALTH PLAN.

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

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2 statutes is repealed and the following is substituted in lieu thereof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

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

12 (b) The commissioner shall impose cost-sharing requirements in
13 connection with services provided under the Charter Oak Health Plan.
14 Such requirements may include, but not be limited to: (1) A monthly
15 premium; (2) an annual deductible not to exceed one thousand dollars;
16 (3) a coinsurance payment not to exceed twenty per cent after the
17 deductible amount is met; (4) tiered copayments for prescription drugs
18 determined by whether the drug is generic or brand name, formulary
19 or nonformulary and whether purchased through mail order; (5) no fee

20 for emergency visits to hospital emergency rooms; (6) a copayment not
21 to exceed one hundred fifty dollars for nonemergency visits to hospital
22 emergency rooms; and (7) a lifetime benefit not to exceed one million
23 dollars.

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

42 (d) The Commissioner of Social Services shall determine minimum
43 requirements on the amount, duration and scope of benefits under the
44 Charter Oak Health Plan, except that there shall be no preexisting
45 condition exclusion and the commissioner shall ensure that the plan
46 includes comprehensive coverage for mental health services consistent
47 with the provisions of section 38a-514. Each participating insurer shall
48 provide an internal grievance process by which an insured may
49 request and be provided a review of a denial of coverage under the
50 plan consistent with the provisions of section 38a-226c. An insured
51 shall also have access to an external appeal process consistent with the
52 provisions of section 38a-478n, and each participating insurer shall

53 comply with the notification and other requirements of the external
54 appeal process.

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

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

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

82 (2) The independent actuary hired pursuant to subdivision (1) of
83 this subsection shall: (A) Report the findings of the analyses conducted
84 pursuant to subdivision (1) of this subsection and make

85 recommendations on the plan, design, pricing and sustainability of the
86 Charter Oak Health Plan to the joint standing committee of the General
87 Assembly having cognizance of matters relating to human services and
88 to the Department of Social Services.

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

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

104 **[**(g)**]** (j) The Commissioner of Social Services, pursuant to section
105 17b-10, may implement policies and procedures to administer the
106 provisions of this section while in the process of adopting such policies
107 and procedures as regulation, provided the commissioner prints notice
108 of the intent to adopt the regulation in the Connecticut Law Journal
109 not later than twenty days after the date of implementation. Such
110 policies shall be valid until the time final regulations are adopted and
111 may include **[**: (1) Exceptions to the requirement that a resident be
112 uninsured for at least six months to be eligible for the Charter Oak
113 Health Plan; and (2)**]** requirements for open enrollment and limitations
114 on the ability of enrollees to change plans between such open
115 enrollment periods.

116 Sec. 2. Section 38a-479aa of the 2008 supplement to the general

117 statutes is amended by adding subsection (n) as follows (*Effective July*
118 *1, 2008*):

119 (NEW) (n) The requirements of subsections (h) and (i) of this section
120 shall not apply to a consortium of federally qualified health centers
121 funded by the state providing services only to recipients of programs
122 administered by the Department of Social Services. Any such provider
123 shall be certified by the Commissioner of Social Services in accordance
124 with criteria established by the commissioner, including, but not
125 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*