



# House of Representatives

General Assembly

**File No. 315**

*January Session, 2009*

Substitute House Bill No. 6152

*House of Representatives, March 30, 2009*

The Committee on Insurance and Real Estate reported through REP. FONTANA, S. of the 87th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

## ***AN ACT ESTABLISHING A CATASTROPHIC MEDICAL EXPENSES POOL.***

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

1 Section 1. (NEW) (*Effective July 1, 2009*) As used in sections 1 to 8,  
2 inclusive, of this act:

3 (1) "Commission" means the Catastrophic Medical Expenses  
4 Commission established pursuant to section 3 of this act.

5 (2) "Family income" means all net income from all sources received  
6 by a family in a calendar year, excluding payments or reimbursements  
7 received from the pool.

8 (3) "Pool" means the catastrophic medical expenses pool established  
9 pursuant to section 2 of this act.

10 Sec. 2. (NEW) (*Effective July 1, 2009*) (a) There is established a  
11 catastrophic medical expenses pool to provide payment or

12 reimbursement for medical and related expenses beginning January 1,  
13 2010, that exceed the family income levels set forth in section 6 of this  
14 act. The Office of the Healthcare Advocate shall administer the pool in  
15 accordance with the provisions of sections 1 to 8, inclusive, of this act  
16 and with the advice of the Catastrophic Medical Expenses  
17 Commission.

18 (b) Services, equipment and other expenses eligible to be considered  
19 for payment or reimbursement from the pool, subject to the limitations  
20 and exclusions set forth in sections 5 and 6 of this act, include, but are  
21 not limited to: (1) Durable medical equipment, hearing aids, medical or  
22 surgical supplies, therapy services and prostheses or orthotics that are  
23 covered benefits but which were denied in whole or in part because  
24 policy or plan limitations have been reached; (2) health insurance (A)  
25 premiums, (B) copayments, (C) deductibles, (D) coinsurance, and (E)  
26 other out-of-pocket expenses paid by an applicant for a covered  
27 benefit; and (3) other items determined by the commission or persons  
28 designated by the commission pursuant to subdivision (14) of  
29 subsection (a) of section 4 of this act to be directly related to the  
30 medical condition of the applicant and necessary to maintain the  
31 health and independence of the applicant or permit such applicant to  
32 continue to remain at home.

33 (c) The commission shall make publicly available a list of medical  
34 and related expenses that are eligible to be considered for payment or  
35 reimbursement from the pool. The commission shall update such list at  
36 least annually.

37 (d) Nothing in sections 1 to 8, inclusive, of this act shall be construed  
38 to require the Office of the Healthcare Advocate or the commission to  
39 make any payment or reimbursement of medical or related expenses to  
40 an applicant.

41 Sec. 3. (NEW) (*Effective July 1, 2009*) (a) There is established a  
42 Catastrophic Medical Expenses Commission within the Office of the  
43 Healthcare Advocate. The commission shall consist of the Healthcare  
44 Advocate, the Commissioners of Social Services and Public Health, the

45 Insurance Commissioner and the Comptroller, or their designees, and  
46 ten additional members as follows:

47 (1) Two appointed by the speaker of the House of Representatives,  
48 one of whom shall be a member of the joint standing committee of the  
49 General Assembly having cognizance of matters relating to insurance;

50 (2) Two appointed by the president pro tempore of the Senate, one  
51 of whom shall be a member of the joint standing committee of the  
52 General Assembly having cognizance of matters relating to insurance;

53 (3) One appointed by the minority leader of the House of  
54 Representatives, upon the recommendation of the president and chief  
55 executive officer of the Connecticut Business and Industry Association  
56 and who shall represent employers that are self-insured;

57 (4) One appointed by the minority leader of the Senate, who shall  
58 represent the health insurance industry;

59 (5) Two appointed by the Attorney General, who shall be licensed  
60 health care providers who currently provide health care services to  
61 residents of the state; and

62 (6) Two appointed by the Governor, one of whom shall be a senior  
63 manager or human resources director of a labor union that offers a  
64 Taft-Hartley plan.

65 (b) The members appointed under subdivisions (1) to (6), inclusive,  
66 of subsection (a) of this section shall serve for terms of five years,  
67 except that the initial two members appointed by the Governor shall  
68 serve for terms of three and four years, respectively. Any vacancy shall  
69 be filled by the appointing authority. Members may be reappointed to  
70 serve consecutive terms. Members shall serve without compensation  
71 for their services but shall be reimbursed for their expenses.

72 (c) Any member appointed under subdivisions (1) to (6), inclusive,  
73 of subsection (a) of this section may be removed for cause, after a  
74 public hearing, by the official who appointed such member and may

75 be suspended by such official pending the completion of such hearing.

76 (d) The members shall elect a chairperson and a secretary of the  
77 commission, neither of whom shall be a member of the General  
78 Assembly. The commission shall, by rule, determine the term of office  
79 of the chairperson and the secretary.

80 (e) Eight members of the commission shall constitute a quorum at  
81 any meeting. A vacancy in the membership of the commission shall  
82 not impair the right of a quorum to exercise all the powers and  
83 perform all the duties of the commission.

84 (f) The members of the commission shall be appointed not later than  
85 November 1, 2009, and the committee shall organize as soon as may be  
86 practicable after such appointment.

87 Sec. 4. (NEW) (*Effective July 1, 2009*) (a) The Catastrophic Medical  
88 Expenses Commission shall have the following powers and duties:

89 (1) To develop an application and establish procedures for applying  
90 to the Office of the Healthcare Advocate for payment or  
91 reimbursement of medical and related expenses from the pool;

92 (2) To establish rules and procedures for determining the eligibility  
93 of applicants and the eligibility of requests for payment or  
94 reimbursement of medical and related expenses from the pool,  
95 including, but not limited to, (A) the documentation or information  
96 required from the applicant to substantiate the eligibility of the  
97 applicant or the request for payment or reimbursement, (B) methods to  
98 verify family income, (C) limits, if any, on the number of times an  
99 applicant may apply in a calendar year, (D) limits, if any, on the dollar  
100 amount that may be paid to an applicant in a calendar year, (E)  
101 whether an application submitted by a member of an applicant's  
102 family or payment made to such family member is aggregated in any  
103 such limits imposed on an applicant, (F) methods to verify previous  
104 payments to an applicant, if necessary, and (G) methods to verify other  
105 available sources of payment have been exhausted;

106 (3) To establish an approval process, including, but not limited to,  
107 any criteria to be used to prioritize payments or reimbursements made  
108 from the pool, except that in the event the moneys in the account  
109 established under section 8 of this act are inadequate to cover all the  
110 requests made for payment or reimbursement, any applicant who is  
111 transitioning to medically needy status under the Medicaid program  
112 and who otherwise meets the criteria under sections 5 and 6 of this act  
113 shall be given preference for payment of reimbursement from the pool;

114 (4) To establish procedures for an applicant notification process,  
115 including, but not limited to, the time frames for the Office of the  
116 Healthcare Advocate to approve or deny an application or request for  
117 payment or reimbursement and for applicants to submit additional  
118 information if a denial was based on incomplete information;

119 (5) To establish a list of services, programs, treatments, products  
120 and expenses excluded under subsection (c) of section 6 of this act;

121 (6) To develop payment rates in accordance with subdivision (1) of  
122 subsection (a) of section 7 of this act;

123 (7) To establish criteria for and procedures to (A) preapprove  
124 payments pursuant to section 7 of this act, and (B) make payments or  
125 reimbursements, including, but not limited to, the method of payment  
126 and time frame for the Office of the Healthcare Advocate to process  
127 such payment;

128 (8) To establish procedures for repayment by an applicant to the  
129 pool where such applicant, after receiving payment from the pool,  
130 recovers the costs of medical and related expenses pursuant to a  
131 settlement or judgment in a legal action;

132 (9) To establish procedures by which moneys in the account  
133 established under section 8 of this act shall be expended, taking into  
134 consideration payments that have been preapproved pursuant to  
135 section 7 of this act and administrative costs to be paid as set forth in  
136 section 8 of this act;

137 (10) To develop an asset test to be used if pool funds appear to be  
138 inadequate to cover requests for payment or reimbursement;

139 (11) To make publicly available and update at least annually a list of  
140 (A) medical and related expenses that are eligible to be considered for  
141 payment or reimbursement from the pool, subject to the limitations  
142 and exclusions under sections 5 and 6 of this act, and (B) exclusions  
143 established pursuant to this subsection;

144 (12) To establish and maintain a record, electronic or otherwise, of  
145 each applicant. Such records shall be maintained in a secure location,  
146 shall be confidential and shall not be disclosed except as required by  
147 law and to members of the commission, provided such members  
148 agree, in writing, to keep such records confidential;

149 (13) To disseminate information to the public concerning the pool,  
150 including, but not limited to, the benefits available from the pool,  
151 procedures to apply and contact information for the Office of the  
152 Healthcare Advocate;

153 (14) To enter into contracts, within the moneys available in the pool,  
154 to carry out the provisions of sections 1 to 8, inclusive, of this act,  
155 including, but not limited to, entering into contracts with licensed  
156 physicians and clinicians to assist the commission in performing its  
157 duties and to designate persons who have the appropriate expertise to  
158 assist the commission in performing its duties;

159 (15) To accept grants of private or federal funds to the pool, and to  
160 accept gifts, donations or bequests including donations of services; and

161 (16) To take any other action necessary to carry out the provisions of  
162 sections 1 to 8, inclusive, of this act.

163 (b) The commission shall adopt regulations, in accordance with  
164 chapter 54 of the general statutes, to implement the provisions of  
165 subdivisions (1) to (10), inclusive, of subsection (a) of this section. The  
166 commission may adopt regulations, in accordance with chapter 54 of  
167 the general statutes, to implement any other provision of sections 1 to

168 8, inclusive, of this act.

169 Sec. 5. (NEW) (*Effective July 1, 2009*) To be eligible to apply for  
170 payment or reimbursement from the pool, a person shall:

171 (1) Be covered by:

172 (A) An individual or group health insurance policy providing  
173 coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)  
174 of section 38a-469 of the general statutes;

175 (B) A self-insured comprehensive group medical or health care  
176 benefit plan. The Catastrophic Medical Expenses Commission shall  
177 determine what constitutes a comprehensive plan for the purposes of  
178 this subparagraph;

179 (C) The Municipal Employee Health Insurance Plan set forth in  
180 section 5-259 of the general statutes;

181 (D) The Charter Oak Health Plan set forth in section 17b-311 of the  
182 general statutes;

183 (E) A comprehensive individual or group health care plan set forth  
184 in section 38a-552 or 38a-554 of the general statutes;

185 (F) Medicare and a Medicare supplement insurance policy; or

186 (G) A high deductible plan, as defined in Section 220(c)(2) or Section  
187 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent  
188 corresponding internal revenue code of the United States, as amended  
189 from time to time, used to establish a "medical savings account" or  
190 "Archer MSA" pursuant to Section 220 of said Internal Revenue Code  
191 or a "health savings account" pursuant to Section 223 of said Internal  
192 Revenue Code, provided such medical savings account or health  
193 savings account has been exhausted and subsequent medical and  
194 related expenses exceed the limits established in section 6 of this act.

195 (2) Not be eligible for benefits under Medicaid, HUSKY Plan or  
196 state-administered general assistance on the date the medical or

197 related expenses for which reimbursement is requested from the pool  
198 were incurred;

199 (3) Be a resident of this state;

200 (4) Be a citizen or resident alien of the United States; and

201 (5) Have exhausted other sources of payment for the requested  
202 payment or reimbursement.

203 Sec. 6. (NEW) (*Effective July 1, 2009*) (a) The amount of payment or  
204 reimbursement in a calendar year shall be limited to:

205 (1) For family income that is less than or equal to two hundred per  
206 cent of the federal poverty level, medical and related expenses paid by  
207 an applicant in a calendar year that are in excess of eight per cent of  
208 such family income;

209 (2) For family income that is greater than two hundred per cent but  
210 less than or equal to three hundred per cent of the federal poverty  
211 level, medical and related expenses paid by an applicant in a calendar  
212 year that are in excess of nine per cent of such family income;

213 (3) For family income that is greater than three hundred per cent but  
214 less than or equal to four hundred per cent of the federal poverty level,  
215 medical and related expenses paid by an applicant in a calendar year  
216 that are in excess of ten per cent of such family income;

217 (4) For family income that is greater than four hundred per cent but  
218 less than or equal to five hundred per cent of the federal poverty level,  
219 medical and related expenses paid by an applicant in a calendar year  
220 that are in excess of twelve and one-half per cent of such family  
221 income;

222 (5) For family income that is greater than five hundred per cent but  
223 less than or equal to one thousand per cent of the federal poverty level,  
224 medical and related expenses paid by an applicant in a calendar year  
225 that are in excess of fifteen per cent of such family income; and

226 (6) For family income that is greater than one thousand per cent but  
227 less than or equal to one thousand three hundred per cent of the  
228 federal poverty level, medical and related expenses paid by an  
229 applicant in a calendar year that are in excess of twenty-five per cent of  
230 such family income.

231 (b) An applicant with a family income that is greater than one  
232 thousand three hundred per cent of the federal poverty level shall not  
233 be eligible for payment or reimbursement from the pool.

234 (c) The following expenses shall be excluded from payment or  
235 reimbursement from the pool:

236 (1) Costs for services that would normally be provided by or  
237 available through (A) the birth-to-three program set forth in section  
238 17a-248 of the general statutes, (B) the Department of Developmental  
239 Services, (C) the Department of Mental Health and Addiction Services,  
240 (D) the Department of Public Health, or (E) an individualized family  
241 service plan pursuant to section 17a-248e of the general statutes, an  
242 individualized education program pursuant to section 10-76d of the  
243 general statutes or any other individualized service plan. Such costs  
244 may be eligible for payment or reimbursement from the pool at the  
245 discretion of the Office of the Healthcare Advocate if the applicant was  
246 ineligible for such services due to the financial eligibility criteria of a  
247 program or agency or due to a limit on the number of clients served by  
248 such program or agency;

249 (2) Costs for long-term care provided in a nursing home facility,  
250 rehabilitation facility or at home that exceeds or is expected to exceed  
251 six months;

252 (3) Premiums, copayments, deductibles, coinsurance and other out-  
253 of-pocket expenses paid by an applicant for a long-term care policy;

254 (4) Items that were denied because the insured or enrollee failed to  
255 comply with the terms of the insurer such as network or prior  
256 authorization requirements;

257 (5) Items that are not cost-effective or appropriate for the applicant's  
258 medical condition, as determined by the commission or persons  
259 designated by the commission pursuant to subdivision (14) of  
260 subsection (a) of section 4 of this act. Such determination may be made  
261 separately from any decision made by an insurer, health care center or  
262 utilization review company concerning such items. If said commission  
263 disagrees with such decision made by an insurer, health care center or  
264 utilization review company, said commission may be a party to an  
265 appeal filed by the applicant with such insurer, health care center or  
266 utilization review company;

267 (6) Infertility diagnosis and treatments;

268 (7) Massage services, natureopathy and other alternative medicine  
269 treatments or services;

270 (8) Dental braces, dentures, cosmetic dental procedures and routine  
271 dental services including, but not limited to, fillings, cleanings and  
272 other prophylaxis measures;

273 (9) Eyeglass frames costing over fifty dollars, adjusted annually by  
274 the increase in the consumer price index for urban consumers during  
275 the preceding twelve-month period according to the United States  
276 Bureau of Labor Statistics data;

277 (10) Pharmaceutical products, biological products or any substance  
278 that may be lawfully sold over the counter without a prescription  
279 under the federal Food, Drug and Cosmetics Act, 21 USC 301 et seq., as  
280 amended from time to time;

281 (11) Vitamins or food supplements, unless prescribed for a  
282 diagnosed medical condition;

283 (12) Cosmetics;

284 (13) Services, treatments or products that are more expensive than  
285 equally effective alternatives, as determined by the commission or  
286 persons designated by the commission pursuant to subdivision (14) of

287 subsection (a) of section 4 of this act; and

288 (14) Other programs, services or expenses the commission may  
289 choose to exclude pursuant to regulations adopted in accordance with  
290 chapter 54 of the general statutes.

291 (d) Payment or reimbursement from the pool for wheelchairs and  
292 hearing aids shall be limited to: (1) Once every biennium for persons  
293 under the age of eighteen years; and (2) once every ten years for  
294 persons over the age of eighteen years.

295 Sec. 7. (NEW) (*Effective July 1, 2009*) (a) If payment of a medical or  
296 related expense is preapproved by the Office of the Healthcare  
297 Advocate:

298 (1) Said office shall remit such payment to the insured's or enrollee's  
299 health care provider at the Medicare allowable rate for such medical or  
300 related expense. If there is no comparable Medicare allowable rate,  
301 said office, with the advice of the Catastrophic Medical Expenses  
302 Commission, shall develop a rate based on current Medicaid and  
303 insurer rates, or on rates negotiated by the Healthcare Advocate where  
304 no current Medicaid or insurer rate exists.

305 (2) Said office may preapprove a payment in accordance with the  
306 rules and procedures established by the commission, provided (A) the  
307 insured's or enrollee's health care or services provider has agreed, in  
308 writing, to accept such payment as payment in full on behalf of such  
309 insured or enrollee for such medical or related expense, (B) the insurer,  
310 health care center, self-insured employer, insured or enrollee, as  
311 applicable, provides any documentation or information required by  
312 said office to determine the eligibility of the applicant or the request  
313 for payment, and any previous payments made to such applicant from  
314 the pool, and (C) there are sufficient funds in the pool.

315 (3) Said office may preapprove payment of a related expense not  
316 typically considered medical if the commission or persons designated  
317 by the commission pursuant to subdivision (14) of subsection (a) of

318 section 4 of this act deem such related expense necessary to  
319 maintaining the independence of the applicant or the ability of such  
320 applicant to remain at home.

321 (b) If reimbursement of a medical or related expense is approved by  
322 the Office of the Healthcare Advocate:

323 (1) The applicant shall submit the bill to said office with proof of  
324 payment.

325 (2) Said office may pay all or part of such bill, based on (A) the rate  
326 said office would have paid pursuant to subdivision (1) of subsection  
327 (a) of this section, (B) the appropriateness and necessity of the  
328 particular medical or related expense, and (C) the availability of funds  
329 in the pool.

330 (c) Notwithstanding the provisions of chapter 319v of the general  
331 statutes, any payment or reimbursement to an applicant from the pool  
332 shall not be counted as income or assets for the purposes of  
333 determining eligibility for medical assistance.

334 Sec. 8. (NEW) (*Effective July 1, 2009*) (a) There is established an  
335 account to be known as the "catastrophic medical expenses account",  
336 which shall be a separate, nonlapsing account within the Insurance  
337 Fund established under section 38a-52a of the general statutes. The  
338 account shall contain any moneys required by law to be deposited in  
339 the account. Moneys in the account shall be expended by the Office of  
340 the Healthcare Advocate for the purposes of paying or reimbursing  
341 medical and related expenses, paying administrative costs and paying  
342 licensed physicians and clinicians contracted by the Catastrophic  
343 Medical Expenses Commission, in accordance with sections 1 to 8,  
344 inclusive, of this act.

345 (b) (1) Each insurer or health care center that delivers, issues for  
346 delivery, renews, amends or continues in this state individual or group  
347 health insurance policies or plans and third party administrator that  
348 provides services in this state under an administrative services only

349 contract shall collect one dollar per life covered on January first of each  
350 year and shall remit such moneys to the Office of the Healthcare  
351 Advocate not later than thirty days after collection. All such moneys  
352 shall be deposited in the account set forth in subsection (a) of this  
353 section.

354 (2) The Department of Revenue Services shall collect one dollar per  
355 life covered on January first of each year under the Charter Oak Health  
356 Plan set forth in section 17b-311 of the general statutes and shall remit  
357 such moneys to the Office of the Healthcare Advocate not later than  
358 thirty days after collection. All such moneys shall be deposited in the  
359 account set forth in subsection (a) of this section.

360 (c) The Office of the Healthcare Advocate shall pay all costs that do  
361 not exceed five per cent of the total amount transferred into the pool in  
362 a calendar year and are related to the management of the pool,  
363 including, but not limited to, costs for staff to manage the program and  
364 coordinate the work assigned by the commission, materials  
365 development, printing, postage and telephone expenses. Any such  
366 expenses that exceed five per cent of the total amount transferred into  
367 the pool in a calendar year shall require approval for payment by the  
368 commission.

369 (d) The Commissioner of Social Services shall seek any federal  
370 matching funds available for the pool.

371 (e) When the moneys in the account have been exhausted, no  
372 payments or reimbursements shall be made until moneys have been  
373 deposited in the succeeding calendar year pursuant to subsection (b) of  
374 this section.

375 Sec. 9. Section 38a-1041 of the general statutes is repealed and the  
376 following is substituted in lieu thereof (*Effective July 1, 2009*):

377 (a) There is established an Office of the Healthcare Advocate which  
378 shall be within the Insurance Department for administrative purposes  
379 only.

380 (b) The Office of the Healthcare Advocate may:

381 (1) Assist health insurance consumers with managed care plan  
382 selection by providing information, referral and assistance to  
383 individuals about means of obtaining health insurance coverage and  
384 services;

385 (2) Assist health insurance consumers to understand their rights and  
386 responsibilities under managed care plans;

387 (3) Provide information to the public, agencies, legislators and  
388 others regarding problems and concerns of health insurance  
389 consumers and make recommendations for resolving those problems  
390 and concerns;

391 (4) Assist consumers with the filing of complaints and appeals,  
392 including filing appeals with a managed care organization's internal  
393 appeal or grievance process and the external appeal process  
394 established under section 38a-478n;

395 (5) Analyze and monitor the development and implementation of  
396 federal, state and local laws, regulations and policies relating to health  
397 insurance consumers and recommend changes it deems necessary;

398 (6) Facilitate public comment on laws, regulations and policies,  
399 including policies and actions of health insurers;

400 (7) Ensure that health insurance consumers have timely access to the  
401 services provided by the office;

402 (8) Review the health insurance records of a consumer who has  
403 provided written consent for such review;

404 (9) Create and make available to employers a notice, suitable for  
405 posting in the workplace, concerning the services that the Healthcare  
406 Advocate provides;

407 (10) Establish a toll-free number, or any other free calling option, to  
408 allow customer access to the services provided by the Healthcare

409 Advocate;

410 (11) Pursue administrative remedies on behalf of and with the  
411 consent of any health insurance consumers;

412 (12) Adopt regulations, pursuant to chapter 54, to carry out the  
413 provisions of sections 38a-1040 to 38a-1050, inclusive; and

414 (13) Take any other actions necessary to fulfill the purposes of  
415 sections 38a-1040 to 38a-1050, inclusive.

416 (c) The Office of the Healthcare Advocate shall make a referral to  
417 the Insurance Commissioner if the Healthcare Advocate finds that a  
418 preferred provider network may have engaged in a pattern or practice  
419 that may be in violation of sections 38a-226 to 38a-226d, inclusive, 38a-  
420 479aa to 38a-479gg, inclusive, or 38a-815 to 38a-819, inclusive.

421 (d) The Healthcare Advocate and the Insurance Commissioner shall  
422 jointly compile a list of complaints received against managed care  
423 organizations and preferred provider networks and the commissioner  
424 shall maintain the list, except the names of complainants shall not be  
425 disclosed if such disclosure would violate the provisions of section 4-  
426 61dd or 38a-1045.

427 (e) On or before October 1, 2005, the Managed Care Ombudsman, in  
428 consultation with the Community Mental Health Strategy Board,  
429 established under section 17a-485b, shall establish a process to provide  
430 ongoing communication among mental health care providers, patients,  
431 state-wide and regional business organizations, managed care  
432 companies and other health insurers to assure: (1) Best practices in  
433 mental health treatment and recovery; (2) compliance with the  
434 provisions of sections 38a-476a, 38a-476b, 38a-488a and 38a-489; and (3)  
435 the relative costs and benefits of providing effective mental health care  
436 coverage to employees and their families. On or before January 1, 2006,  
437 and annually thereafter, the Healthcare Advocate shall report, in  
438 accordance with the provisions of section 11-4a, on the implementation  
439 of this subsection to the joint standing committees of the General

440 Assembly having cognizance of matters relating to public health and  
441 insurance.

442 (f) On or before October 1, 2008, the Office of the Healthcare  
443 Advocate shall, within available appropriations, establish and  
444 maintain a healthcare consumer information web site on the Internet  
445 for use by the public in obtaining healthcare information, including but  
446 not limited to: (1) The availability of wellness programs in various  
447 regions of Connecticut, such as disease prevention and health  
448 promotion programs; (2) quality and experience data from hospitals  
449 licensed in this state; and (3) a link to the consumer report card  
450 developed and distributed by the Insurance Commissioner pursuant to  
451 section 38a-478l.

452 (g) The Office of the Healthcare Advocate shall administer the  
453 catastrophic medical expenses pool established under section 2 of this  
454 act, and shall make payments and reimbursements in accordance with  
455 sections 1 to 8, inclusive, of this act. Said office may adopt regulations,  
456 in accordance with chapter 54, to implement the provisions of sections  
457 1 to 8, inclusive, of this act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	July 1, 2009	New section
Sec. 2	July 1, 2009	New section
Sec. 3	July 1, 2009	New section
Sec. 4	July 1, 2009	New section
Sec. 5	July 1, 2009	New section
Sec. 6	July 1, 2009	New section
Sec. 7	July 1, 2009	New section
Sec. 8	July 1, 2009	New section
Sec. 9	July 1, 2009	38a-1041

**Statement of Legislative Commissioners:**

In sections 2(b), 6(c)(5), 6(c)(13) and 7(a)(3), "subdivision (14) of subsection (a) of" was inserted before "section 4" for clarity and accuracy.

**INS**      *Joint Favorable Subst.*

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 House thereof for any purpose:

### **OFA Fiscal Note**

#### **State Impact:**

Agency Affected	Fund-Effect	FY 10 \$	FY 11 \$
Health Care Access, Off.	IF - None	See Below	See Below

Note: IF=Insurance Fund

**Municipal Impact:** None

#### **Explanation**

This bill creates a Catastrophic Medical Expenses Pool to be administered by the Office of the Healthcare Access (OHA), resulting in costs to OHA for a staff position, fringe benefits, and other expenses, totaling \$138,000 in FY 10 and 140,080 in FY 11 since it is a new program (see below):

Item	FY 10	FY 11
1.0 Insurance Program Manager	\$80,000	\$82,400
Fringe Benefits	\$44,000	\$45,320
Other Expenses (outreach materials, telephone, etc.)	\$10,500	\$10,920
Equipment (computer, office furniture)	\$3,500	\$0
<b>TOTAL</b>	<b>\$138,000</b>	<b>\$138,640</b>

These costs could be paid out of the Catastrophic Medical Expenses Pool account, a separate, non-lapsing account within the Insurance Fund, established in the bill. The account would be funded through a new \$1-per-life-covered assessment on all health insurance providers in the state. Sec. 8 (e) limits payments and cost reimbursement from this account not to exceed the money deposited into it in the succeeding calendar year. OHA estimates that \$1.3 million will be collected in FY 10 and FY 11 from this assessment. After administrative costs, \$1,162,000 in FY 10 and \$1,616,360 in FY 11 would be available in the account for payments for qualifying individuals'

medical and related expenses.

Sec. 8 (c) of the bill requires OHA to pay all costs related to the management of this pool that do not exceed 5% of the funds transferred into the pool account. Costs over 5% would require approval by the Catastrophic Medical Expenses Commission, created in the bill, before OHA may pay these costs. As \$65,000 is 5% of the anticipated \$1-per-life-covered assessment revenue in FY 10 and FY 11, additional costs to OHA of \$73,000 in FY 10 and \$73,640 in FY 11 would need approval by the Commission for payment.

### ***The Out Years***

Costs in the out-years will be paid through the account established in the bill, assuming the Catastrophic Medical Expenses Commission's approval of costs exceeding 5% of the money deposited into the account in the succeeding calendar year.

**OLR Bill Analysis****sHB 6152*****AN ACT ESTABLISHING A CATASTROPHIC MEDICAL EXPENSES POOL.*****SUMMARY:**

This bill establishes (1) the Catastrophic Medical Expenses Commission and (2) a catastrophic medical expenses pool to reimburse or pay for, beginning January 1, 2010, certain medical and related expenses that exceed a certain percentage of a person's family income. Under the bill, the healthcare advocate administers the pool with the commission's advice. The bill specifies that it must not be construed to require the healthcare advocate or commission to reimburse or pay for an applicant's medical or related expenses.

The bill establishes the catastrophic medical expenses account as a separate, nonlapsing account within the Insurance Fund. To fund the account, the bill requires Connecticut health insurers, HMOs, third party administrators, and Department of Revenue Services to collect a fee of \$1 per person covered under health insurance policies and plans, including the Charter Oak Health Plan. It requires the social services commissioner to apply for any available federal matching funds.

(The bill does not specify from whom they collect the fee, e.g., policyholders or each person. And it appears the insurers, HMOs, and administrators collect the fee based on all people, not just Connecticut residents, covered under a plan.)

The bill authorizes the healthcare advocate and the commission, separately, to adopt implementing regulations. And it requires the commission to adopt regulations regarding application procedures and other implementing processes the commission must establish.

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EFFECTIVE DATE: July 1, 2009

## **§§ 3 & 4 — CATASTROPHIC MEDICAL EXPENSES COMMISSION**

### ***Membership***

The bill establishes a 15-member Catastrophic Medical Expenses Commission. The healthcare advocate; comptroller; and social services, public health, and insurance commissioners (or their designees) are members, as well as 10 appointees. Members must be appointed by November 1, 2009. The committee must organize as soon as practicable after members are appointed. Members serve without compensation, but must be reimbursed for expenses.

The 10 appointees are:

1. two members the House speaker appoints, one of whom must be an Insurance and Real Estate Committee member;
2. two members the Senate president pro tempore appoints, one of whom must be an Insurance and Real Estate Committee member;
3. one person representing self-insured employers that the House minority leader appoints upon the Connecticut Business and Industry Association's president and chief executive officer's recommendation;
4. one person representing the health insurance industry that the Senate minority leader appoints;
5. two licensed health care providers practicing in Connecticut that the attorney general appoints; and
6. two members the governor appoints, one of whom must be a senior manager or human resources director of a labor union offering a Taft-Hartley plan (i.e., a health insurance plan or arrangement issued in accordance with a trust established through collective bargaining under the federal Labor Management Relations Act).

Members (1) serve five-year terms, except that the initial two gubernatorial appointees must serve three- and four-year terms, respectively and (2) can be reappointed to serve consecutive terms. The appointing authority (1) fills vacancies and (2) may remove an appointee for cause, after a public hearing. The authority may suspend the appointee pending the hearing's completion.

The members must elect a commission chairperson and secretary, neither of whom can be a legislator. The commission must adopt rules to establish the chairperson's and secretary's office term.

The bill specifies that eight commission members constitutes a quorum at a meeting. A vacancy in the commission's membership does not impair a quorum's right to exercise the commission's powers and duties.

### ***Powers and Duties***

Under the bill, the commission must develop application procedures, and the application, for seeking reimbursement of or payment from the pool. It must establish rules and procedures for the pool, including:

1. how to determine if an applicant or his or her expenses are eligible for funding;
2. documentation or information the applicant must provide to substantiate his or her eligibility or request for payment or reimbursement;
3. methods to verify family income;
4. whether any calendar year limits apply to the (a) number of times a person may apply in a calendar year or (b) dollar amount a person may receive from the pool;
5. whether an application from, or payment to, an applicant's family member counts toward any limits imposed; and

6. methods to verify (a) previous payments to an applicant, if necessary, and (b) that other available sources of payment have been exhausted.

The bill requires the commission to establish an application approval process, including criteria to prioritize pool payments or reimbursements. It specifies that if the deposited fees are insufficient to cover all eligible pool payment requests, the pool must give preference to an applicant who meets the pool's criteria and is "transitioning to medically needy status under Medicaid." (Presumably, this refers to a person who is "spending-down" to qualify for Medicaid (see BACKGROUND).)

The commission must establish:

1. procedures for an applicant notification process, including the time in which (a) the healthcare advocate must approve or deny an application or funding request and (b) an applicant must submit additional information if his or her application was denied because it was incomplete;
2. a list of services, programs, treatments, products, and expenses for which the pool will not pay or reimburse;
3. rates payable to a health care provider for services the commission pre-approves for payment;
4. criteria for, and procedures to, (a) pre-approve payments and (b) make payments or reimbursements, including payment method and time frames;
5. procedures for recouping from a person an amount that the pool paid the person, who subsequently recovers those costs through a settlement of, or judgment in, a legal action;
6. procedures for accessing and spending the account's funds, including for preapproved payments and administrative costs;

7. an asset test to be used if pool funds appear inadequate to cover eligible payment or reimbursement requests;
8. a publicly available list, updated at least annually, of medical and related expenses eligible for, and those excluded from, payment or reimbursement consideration; and
9. a record of each applicant, in electronic or other form.

The bill requires the pool to maintain the applicant records and keep them in a secure location. It makes the records confidential and not subject to disclosure, except (1) as the law requires and (2) to commission members, if the members agree, in writing, to keep them confidential.

The commission must:

1. disseminate information to the public about the pool, including benefits available, procedures to apply, and the healthcare advocate's contact information;
2. enter into contracts, within available pool funds, to implement the bill's provisions, including contracts with licensed physicians and clinicians and people with appropriate expertise to assist the commission in performing its duties;
3. accept private or federal grants for the pool and gifts, donations, or bequests, including donations of services;
4. take any other action necessary to implement the bill's provisions; and
5. adopt regulations to implement specified parts of the bill's provisions relating to the commission's powers and duties.

## **§ 5 — PEOPLE ELIGIBLE TO APPLY TO THE POOL**

Under the bill, a person is eligible to apply for payment or reimbursement from the pool if he or she is:

1. covered under a health insurance policy or plan;
2. not eligible for Medicaid, HUSKY, or state-administered general assistance (SAGA) when he or she incurred the medical or related expenses for which he or she wants pool reimbursement;
3. be a Connecticut resident and a U.S. citizen or resident alien; and
4. have exhausted other payment sources for which he or she wants pool reimbursement.

A person is covered under a health insurance policy or plan if he or she is covered under:

1. an individual or group health insurance policy that covers (a) basic hospital expenses; (b) basic medical-surgical expenses; (c) major medical expenses; and (d) hospital or medical services, including coverage under an HMO plan;
2. a self-insured comprehensive group medical or health care benefit plan, as determined by the commission;
3. the Municipal Employee Health Insurance Plan (MEHIP);
4. the Charter Oak Health Plan;
5. a comprehensive individual or group health care plan as specified in state law;
6. Medicare and a Medicare supplement insurance policy; or
7. a high-deductible health plan designed to be compatible with a federally qualified medical or health savings account, if the person has exhausted the account and subsequent medical and related expenses exceed the bill's family income limits.

## **§ 6 — POOL REIMBURSEMENTS AND PAYMENTS**

### ***Limited Based on Family Income***

The bill limits the amount the pool can pay or reimburse to a person

(see Table 1). The limit is based on the amount the person paid in a calendar year for medical and related expenses and the person's family income, which is based on the federal poverty level (FPL). (In 2009, FPL for a family of three is \$36,620).

The bill defines "family income" as all net income from all sources a family receives in a calendar year, excluding reimbursements or payments from the pool.

**TABLE 1**

<b><i>If a Person's Family Income is:</i></b>	<b><i>Then Pool Payments and Reimbursements are Limited to Expenses the Person Paid in a Calendar Year that Exceed:</i></b>
200% of FPL or less	8% of family income
> 200% of FPL to 300% of FPL	9% of family income
> 300% of FPL to 400% of FPL	10% of family income
> 400% of FPL to 500% of FPL	12½% of family income
> 500% of FPL to 1,000% of FPL	15% of family income
> 1,000% of FPL to 1,300% of FPL	25% of family income
> 1,300% of FPL	Not Applicable. Person is not eligible.

### ***Exclusions***

Under the bill, the pool will not reimburse or pay for costs associated with services normally provided by, or available through:

1. Connecticut's Birth-to-Three program;
2. the departments of Developmental Services, Mental Health and Addiction Services, or Public Health; or
3. an individualized family service plan or education program, in accordance with state law, or any other individualized service

plan.

The bill specifies that costs associated with these may be eligible for pool payment or reimbursement at the healthcare advocate's discretion if the applicant was ineligible for services because of (1) the program's or agency's financial eligibility criteria or (2) a limit on the number of clients the program or agency serves.

The pool will not reimburse or pay for:

1. more than six months of long-term care at home or in a nursing home or rehabilitation facility;
2. premiums, copayments, deductibles, coinsurance, and other out-of-pocket expenses an applicant paid for, or under, a long-term care policy;
3. items denied because the insured or enrollee failed to comply with an insurer's network or prior authorization requirements;
4. infertility diagnosis and treatment;
5. massage services, natureopathy, and other alternative medicine treatments or services;
6. dental braces, dentures, cosmetic dental procedures, and routine dental services, including fillings, cleanings, and other prophylaxis measures;
7. eyeglass frames costing more than \$50, adjusted annually for any consumer price index for urban consumers increase in the preceding 12-month period, based on the U.S. Bureau of Labor Statistics data;
8. pharmaceutical or biological products or any substance that may be lawfully sold over the counter without a prescription according to federal law;
9. vitamins or food supplements, unless prescribed for a diagnosed

- medical condition;
10. cosmetics;
  11. programs, services, or expenses the commission chooses to exclude under regulations it adopts;
  12. services, treatments, or products that are more expensive than equally effective alternatives, as determined by the commission or its designees; and
  13. items that are not cost-effective or appropriate for the applicant's medical condition, as determined by the commission or its designees.

According to the bill, the commission's determination relating to cost-effectiveness or appropriateness may be made separately from an insurer's, HMO's, or utilization review (UR) company's determination. If the commission disagrees with an entity's determination, the bill permits it to be a party to an appeal the applicant may file with the entity.

### ***Limitation***

The bill limits pool payment or reimbursement for wheelchairs and hearing aids to once every (1) two years for a child under age 18 and (2) 10 years for a person over the age of 18. (The bill does not establish a limit for a person who is age 18.)

## **§ 2 — EXPENSES ELIGIBLE FOR REIMBURSEMENT OF PAYMENT**

Under the bill, the services, equipment, and other expenses eligible for payment or reimbursement consideration, subject to the bill's specified limitations and exclusions, include:

1. durable medical equipment, hearing aids, medical or surgical supplies, therapy services, and prostheses or orthotics that are covered benefits but were denied in whole or part because a policy or plan limitation was reached;

2. health insurance premiums, copayments, deductibles, coinsurance, and other out-of-pocket expenses an applicant paid for a covered benefit; and
3. other items the commission or its designees determine are (a) directly related to the applicant's medical condition and (b) necessary to maintain his or her health and independence or permit him or her to remain at home.

## **§ 7 — POOL PAYMENT AND REIMBURSEMENT**

### ***Pre-Approved Payments***

The bill permits the healthcare advocate to pre-approve medical or related expenses for payment from the pool. The payments must be made directly to the healthcare provider, in accordance with the bill's provisions.

The healthcare advocate must remit payment to the provider in an amount that equals Medicare's allowable rate for that service or expense. If there is no comparable Medicare allowable rate, the healthcare advocate, with the commission's advice, must develop a rate based on (a) current Medicaid and insurer rates or (b) rates he negotiates if no current Medicaid or insurer rate exists.

The bill allows the healthcare advocate to pre-approve a payment in accordance with rules and procedures the commission establishes, if:

1. the insured's or enrollee's provider has agreed, in writing, to accept the payment as payment in full;
2. the insurer, health care center, self-insured employer, insured, or enrollee, provides documentation or information the healthcare advocate requests to determine the pool eligibility, including any previous pool payments to the applicant; and
3. the pool has sufficient funds.

Additionally, the healthcare advocate may pre-approve payment for a related expense not typically considered medical if the commission

or its designees deem it necessary to maintaining the applicant's independence or ability to remain at home.

(It is unclear if these provisions, which appear to require the healthcare advocate to contract with providers to provide services in exchange for payment, makes him an unauthorized insurance company or subjects him to preferred provider network or other laws regarding provider contracts.)

### ***Reimbursement of Paid Expenses***

Under the bill, if the healthcare advocate approves reimbursement of a medical or related expense, the applicant must submit the bill to him with proof of payment. The bill permits the healthcare advocate to pay all or part of the bill, based on the:

1. rate he would have paid if he had pre-approved payment,
2. appropriateness and necessity of the expense, and
3. availability of pool funds.

The bill specifies that a pool payment or reimbursement to an applicant will not be counted as income or assets for purposes of determining his or her eligibility for state medical assistance.

## **§ 8 — ACCOUNT AND FEES**

### ***Account Established***

The bill establishes the catastrophic medical expenses account as a separate, nonlapsing account within the Insurance Fund. The healthcare advocate must use the account, which will receive specified deposits, to pay or reimburse eligible, approved expenses as provided under the bill.

### ***Covered Lives Fee***

To fund the account, the bill requires Connecticut health insurers, HMOs, and third party administrators to collect on January 1<sup>st</sup> of each year, a fee of \$1 per life covered. (Presumably, they collect, from each

policyholder or plan sponsor, \$1 for each person covered under the policy or plan. It is unclear how they will collect the fee on January 1. Maybe they are supposed to collect the fee annually by January 1.) The bill also requires DRS to collect a fee of \$1 per person covered under the Charter Oak Health Plan. (It is unclear from whom DRS collects the fee and by when.)

The bill requires the companies and DRS to remit the fees, within 30 days of collecting them, to the healthcare advocate for deposit into the account. It requires the healthcare advocate to pay pool administration expenses up to 5% of fees collected. The expenses must relate to the pool's management, including (1) costs for staff to manage the program and coordinate work the commission assigns; (2) developing program material; and (3) printing, postage, and telephone costs. The bill requires him to obtain the commission's approval to pay any expenses exceeding the 5% amount.

### ***Federal Matching Funds***

It requires the social services commissioner to apply for any available federal matching funds.

### ***Pool Makes Payments Each Year Until Funds are Exhausted***

The bill specifies that once account funds are exhausted in a given calendar year, no pool payments or reimbursements will be made for the remainder of the year. Pool payments and reimbursements resume after money is deposited in the next calendar year.

## **BACKGROUND**

### ***Spending Down***

Federal law gives states the option of providing Medicaid to groups of individuals who do not qualify for benefits because they do not fit into a particular category (e.g., cash assistance recipient). One such group is the "medically needy," comprised of people who do not qualify for cash assistance because their income exceeds a specified limit, even though they meet other categorical eligibility standards (such as disability).

In Connecticut, a person in this situation is permitted to “spend down” the excess income on certain medical or remedial services over a six-month period. Once they spend down to the income limit, the person receives Medicaid coverage for the rest of the six-month period.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 16 Nay 2 (03/12/2009)