



House of Representatives

General Assembly

File No. 8

February Session, 2010

Substitute House Bill No. 5013

House of Representatives, March 3, 2010

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, 2010*) As used in sections 1 to 9,
2 inclusive, of this act:

3 (1) "Applicant" means a child or a family member of a child who is
4 applying for payment or reimbursement from the pool for medical and
5 related expenses for such child.

6 (2) "Child" means a person eighteen years of age or younger.

7 (3) "Commission" means the Catastrophic Medical Expenses
8 Advisory Commission established pursuant to section 3 of this act.

9 (4) "Family" means a child, any siblings of such child and (A) one or
10 more biological or adoptive parents, (B) one or more persons to whom
11 legal custody or guardianship has been given, or (C) one or more

12 adults who have a primary responsibility to pay for medical care for
13 such child.

14 (5) "Family income" means all net income from all sources received
15 by a family on an annualized basis, excluding payments or
16 reimbursements received from the pool.

17 (6) "Pool" means the catastrophic medical expenses pool established
18 pursuant to section 2 of this act.

19 Sec. 2. (NEW) (*Effective July 1, 2010*) (a) There is established a
20 catastrophic medical expenses pool to provide payment or
21 reimbursement for medical and related expenses incurred for a child
22 on or after January 1, 2011, whose family's medical and related
23 expenses exceed the threshold levels set forth in section 6 of this act.
24 The Office of the Healthcare Advocate shall administer the pool in
25 accordance with the provisions of sections 1 to 9, inclusive, of this act
26 and with the advice of the Catastrophic Medical Expenses Advisory
27 Commission.

28 (b) Services, equipment and other expenses incurred for a child that
29 are eligible to be considered for payment or reimbursement from the
30 pool, subject to the limitations and exclusions set forth in sections 5
31 and 6 of this act, include, but are not limited to: (1) Durable medical
32 equipment, hearing aids, medical or surgical supplies, therapy services
33 and prostheses or orthotics that are covered benefits under such child's
34 insurance policy or plan but which were denied in whole or in part
35 because policy or plan limitations have been reached, except that
36 payment or reimbursement from the pool for (A) wheelchairs and
37 hearing aids shall be limited to once every biennium, and (B) eyeglass
38 frames shall be limited to fifty dollars; (2) any health insurance (A)
39 copayments, (B) deductibles, (C) coinsurance, and (D) other out-of-
40 pocket expenses paid by an applicant, excluding premium payments;
41 and (3) other items determined by the Office of the Healthcare
42 Advocate or persons designated by said office pursuant to subdivision
43 (14) of section 4 of this act to be directly related to the medical
44 condition of the child and necessary to maintain the health of the child

45 or permit such child to remain at home rather than be admitted to a
46 health care facility.

47 (c) The Office of the Healthcare Advocate shall make publicly
48 available a list of medical and related expenses that are eligible to be
49 considered for payment or reimbursement from the pool. Said office
50 shall update such list each time said office makes a change and shall
51 review such list at least annually.

52 (d) Nothing in sections 1 to 9, inclusive, of this act shall be construed
53 to require said office to make any payment or reimbursement of
54 medical or related expenses to an applicant.

55 Sec. 3. (NEW) (*Effective July 1, 2010*) There is established a
56 Catastrophic Medical Expenses Advisory Commission to advise the
57 Office of the Healthcare Advocate to carry out the provisions of
58 sections 1 to 9, inclusive, of this act. The commission shall consist of
59 the Healthcare Advocate, the Commissioners of Social Services and
60 Public Health, the Insurance Commissioner and the Comptroller, or
61 their designees, and additional members appointed by the Healthcare
62 Advocate that shall include one or more (1) members of the joint
63 standing committee of the General Assembly having cognizance of
64 matters relating to insurance, (2) members of the general public, (3)
65 licensed health care providers who currently provide health care
66 services to residents of the state, (4) representatives of the health
67 insurance industry, (5) representatives of employers that are self-
68 insured, and (6) senior managers or human resources directors of a
69 labor union that offers a Taft-Hartley plan.

70 Sec. 4. (NEW) (*Effective July 1, 2010*) In order to carry out the
71 provisions of sections 1 to 9, inclusive, of this act, the Office of the
72 Healthcare Advocate shall have the following powers and duties:

73 (1) To develop an application and establish procedures for applying
74 to said office for payment or reimbursement of medical and related
75 expenses from the pool;

76 (2) To establish rules and procedures for determining the eligibility
77 of applicants and the eligibility of requests for payment or
78 reimbursement of medical and related expenses from the pool,
79 including, but not limited to, (A) the documentation or information
80 required from the applicant to substantiate the eligibility of the
81 applicant or the request for payment or reimbursement, (B) methods to
82 verify family income, (C) limits, if any, on the number of times an
83 applicant may apply in a calendar year, (D) limits, if any, on the dollar
84 amount that may be paid to an applicant in a calendar year, (E)
85 methods to verify previous payments to an applicant, if necessary, (F)
86 methods to verify that the payment or reimbursement sought has not
87 been paid by insurance or provided free of charge to the applicant, and
88 (G) methods to verify other available sources of payment have been
89 exhausted;

90 (3) To establish an approval process, including, but not limited to,
91 any criteria to be used to prioritize payments or reimbursements made
92 from the pool, except that in the event the moneys in the account
93 established under section 9 of this act are inadequate to cover all the
94 requests made for payment or reimbursement, any applicant who is
95 transitioning to medically needy status under the Medicaid program
96 and who otherwise meets the criteria under sections 5 and 6 of this act
97 shall be given preference for payment or reimbursement from the pool;

98 (4) To establish procedures for an applicant notification process,
99 including, but not limited to, the time frames for said office to approve
100 or deny an application or request for payment or reimbursement and
101 for applicants to submit additional information if a denial was based
102 on incomplete information;

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

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

107 (7) To establish criteria for and procedures to (A) preapprove

108 payments pursuant to section 7 of this act, and (B) make payments or
109 reimbursements, including, but not limited to, the method of payment
110 and time frame for said office to process such payment;

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

115 (9) To establish procedures by which moneys in the account
116 established under section 9 of this act shall be expended, taking into
117 consideration payments that have been preapproved pursuant to
118 section 7 of this act and administrative costs to be paid as set forth in
119 section 9 of this act;

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

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

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

132 (13) To disseminate information to the public concerning the pool,
133 including, but not limited to, the benefits available from the pool,
134 procedures to apply and contact information for said office;

135 (14) To enter into contracts, within the moneys available in the pool,
136 to carry out the provisions of sections 1 to 9, inclusive, of this act,
137 including, but not limited to, entering into contracts with licensed
138 physicians and clinicians to assist said office in performing its duties

139 and to designate persons who have the appropriate expertise to assist
140 said office in performing its duties. Nothing in this subdivision shall be
141 construed to prohibit said office from seeking such services on a
142 volunteer basis;

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

146 (16) To take any other action necessary to carry out the provisions of
147 sections 1 to 9, inclusive, of this act.

148 Sec. 5. (NEW) (*Effective July 1, 2010*) To be eligible for payment or
149 reimbursement from the pool, a child shall:

150 (1) Be covered by:

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

154 (B) A self-insured comprehensive group medical or health care
155 benefit plan. The Office of the Healthcare Advocate shall determine
156 what constitutes a comprehensive plan for the purposes of this
157 subparagraph;

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

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

162 (E) A high deductible plan, as defined in Section 220(c)(2) or Section
163 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent
164 corresponding internal revenue code of the United States, as amended
165 from time to time, used to establish a "medical savings account" or
166 "Archer MSA" pursuant to Section 220 of said Internal Revenue Code
167 or a "health savings account" pursuant to Section 223 of said Internal

168 Revenue Code, provided such medical savings account or health
169 savings account has been exhausted and a family's subsequent medical
170 and related expenses exceed the threshold levels established in section
171 6 of this act;

172 (2) Not be eligible for benefits under Medicaid, the HUSKY Plan or
173 state-administered general assistance on the date the medical or
174 related expenses for which reimbursement is requested from the pool
175 were incurred, except that a child who is eligible to receive benefits
176 under Medicaid or the HUSKY Plan and is covered by an individual or
177 group health insurance policy or plan set forth in subdivision (1) of
178 this section shall be eligible for payment or reimbursement from the
179 pool;

180 (3) Be a resident of this state;

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

182 (5) Have exhausted (A) other sources of third-party payment such
183 as, but not limited to, the child's policy or plan or any applicable state
184 programs, for the requested payment or reimbursement, and (B) all
185 administrative remedies available under the child's policy or plan.

186 Sec. 6. (NEW) (*Effective July 1, 2010*) (a) All family medical and
187 related expenses, subject to the exclusions under subsection (c) of this
188 section, may be counted for the purposes of determining whether an
189 applicant's family medical and related expenses exceeds the threshold
190 levels set forth in this subsection. An applicant shall provide such
191 documentation as is required by the Office of the Healthcare Advocate
192 of the medical and related expenses incurred by such applicant and
193 such applicant's family. Payment or reimbursement from the pool for
194 medical and related expenses incurred for a child in a year shall be
195 limited to:

196 (1) For family income that is less than or equal to two hundred per
197 cent of the federal poverty level, medical and related expenses paid by
198 an applicant and an applicant's family in a year that are in excess of

199 eight per cent of such family income;

200 (2) For family income that is greater than two hundred per cent but
201 less than or equal to three hundred per cent of the federal poverty
202 level, medical and related expenses paid by an applicant and an
203 applicant's family in a year that are in excess of nine per cent of such
204 family income;

205 (3) For family income that is greater than three hundred per cent but
206 less than or equal to four hundred per cent of the federal poverty level,
207 medical and related expenses paid by an applicant and an applicant's
208 family in a year that are in excess of ten per cent of such family income;

209 (4) For family income that is greater than four hundred per cent but
210 less than or equal to five hundred per cent of the federal poverty level,
211 medical and related expenses paid by an applicant and an applicant's
212 family in a year that are in excess of twelve and one-half per cent of
213 such family income;

214 (5) For family income that is greater than five hundred per cent but
215 less than or equal to one thousand per cent of the federal poverty level,
216 medical and related expenses paid by an applicant and an applicant's
217 family in a year that are in excess of fifteen per cent of such family
218 income;

219 (6) For family income that is greater than one thousand per cent but
220 less than or equal to one thousand five hundred per cent of the federal
221 poverty level, medical and related expenses paid by an applicant and
222 an applicant's family in a year that are in excess of twenty per cent of
223 such family income;

224 (7) For family income that is greater than one thousand five
225 hundred per cent but less than or equal to two thousand per cent of the
226 federal poverty level, medical and related expenses paid by an
227 applicant and an applicant's family in a year that are in excess of
228 twenty-five per cent of such family income; and

229 (8) For family income that is greater than two thousand per cent but

230 less than or equal to two thousand five hundred per cent of the federal
231 poverty level, medical and related expenses paid by an applicant and
232 an applicant's family in a year that are in excess of thirty per cent of
233 such family income.

234 (b) An applicant with a family income that is greater than two
235 thousand five hundred per cent of the federal poverty level shall not
236 be eligible for payment or reimbursement from the pool.

237 (c) The following shall not be counted as expenses for the purposes
238 of determining whether an applicant's family medical and related
239 expenses exceeds the threshold levels set forth in subsection (a) of this
240 section, and shall be excluded from payment or reimbursement from
241 the pool:

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

255 (2) Costs for long-term care provided in a group home, nursing
256 home facility, rehabilitation facility, transitional or mental health
257 facility, chronic and convalescent hospital or other residential facility,
258 or at home that exceeds or is expected to exceed six months;

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

261 (4) Premiums paid by an applicant for any health insurance policy
262 or medical benefits plan, including, but not limited to, vision or dental
263 plans;

264 (5) Items that were denied because the insured or enrollee failed to
265 comply with the terms of the insurer such as network or prior
266 authorization requirements;

267 (6) Items that are not cost-effective or appropriate for the child's
268 medical condition, as determined by the Office of the Healthcare
269 Advocate or persons designated by said office pursuant to subdivision
270 (14) of section 4 of this act. Such determination may be made
271 separately from any decision made by an insurer, health care center or
272 utilization review company concerning such items. If said office
273 disagrees with such decision made by an insurer, health care center or
274 utilization review company, said office may be a party to an appeal
275 filed by the applicant with such insurer, health care center or
276 utilization review company;

277 (7) Infertility diagnosis and treatments;

278 (8) Massage services, natureopathy and other alternative medicine
279 treatments or services;

280 (9) Dental braces, dentures, cosmetic dental procedures and routine
281 dental services, including, but not limited to, fillings, cleanings and
282 other prophylaxis measures;

283 (10) Vision correction services, including, but not limited to, LASIK
284 surgery;

285 (11) Pharmaceutical products, biological products or any substance
286 that may be lawfully sold over the counter without a prescription
287 under the federal Food, Drug and Cosmetics Act, 21 USC 301 et. seq.,
288 as amended from time to time;

289 (12) Vitamins or food supplements, unless prescribed for a
290 diagnosed medical condition;

291 (13) Cosmetics or anything used or worn solely to improve
292 appearance;

293 (14) Services, treatments or products that are more expensive than
294 equally effective alternatives, as determined by the Office of the
295 Healthcare Advocate or persons designated by said office pursuant to
296 subdivision (14) of section 4 of this act; and

297 (15) Other programs, services or expenses said office may choose to
298 exclude pursuant to regulations that the Office of the Healthcare
299 Advocate may adopt in accordance with chapter 54 of the general
300 statutes.

301 Sec. 7. (NEW) (*Effective July 1, 2010*) (a) If payment of a medical or
302 related expense is preapproved by the Office of the Healthcare
303 Advocate:

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

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

320 (3) Said office may preapprove payment of a related expense not
321 typically considered medical if said office or persons designated by

322 said office pursuant to subdivision (14) of section 4 of this act deem
323 such related expense necessary to maintaining the health of the child
324 or the ability of such child to remain at home rather than be admitted
325 to a health care facility.

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

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

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

335 (c) Notwithstanding any provision of the general statutes, said
336 office shall not be deemed to be a preferred provider network, as
337 defined in section 38a-479aa of the general statutes, or an unauthorized
338 insurer, as defined in section 38a-1 of the general statutes.

339 Sec. 8. (NEW) (*Effective July 1, 2010*) (a) For the purposes of this
340 section, the catastrophic medical expenses pool established pursuant to
341 section 2 of this act shall be deemed to be a public assistance program.

342 (b) Notwithstanding the provisions of chapter 319v of the general
343 statutes, any payment or reimbursement to an applicant from the pool
344 shall not be counted as income by the Department of Social Services
345 for the purposes of determining eligibility for medical assistance, but
346 such payment or reimbursement to an applicant who is also an
347 applicant for medical assistance pursuant to section 17b-261 of the
348 general statutes shall be considered an incurred expense paid by a
349 public assistance program that shall be counted for the purposes of
350 reducing excess income of such applicant.

351 Sec. 9. (NEW) (*Effective July 1, 2010*) (a) There is established an
352 account to be known as the "catastrophic medical expenses account",

353 which shall be a separate, nonlapsing account within the Insurance
354 Fund established under section 38a-52a of the general statutes. The
355 account shall contain any moneys required by law to be deposited in
356 the account. Moneys in the account shall be expended by the Office of
357 the Healthcare Advocate for the purposes of paying or reimbursing
358 medical and related expenses, paying administrative costs and paying
359 licensed physicians and clinicians contracted by said office, in
360 accordance with this section and sections 1 to 8, inclusive, of this act.

361 (b) By January 1, 2011, and annually thereafter, each insurer, health
362 care center or other entity that delivers, issues for delivery, renews,
363 amends or continues in this state an individual or group health
364 insurance policy or plan set forth in section 5 of this act and third-party
365 administrator that provides services in this state under an
366 administrative services only contract for a policy or plan set forth in
367 section 5 of this act shall collect one dollar per life covered in this state
368 from each insured or policyholder at the time of renewal and shall
369 remit such moneys to the Office of the Healthcare Advocate not later
370 than thirty days after collection. All such moneys shall be deposited in
371 the account set forth in subsection (a) of this section. A policyholder
372 that has collected and paid such moneys pursuant to this subsection
373 may collect one dollar from each person insured under such policy,
374 provided the total amount collected from such insureds shall not
375 exceed the total amount paid by such policyholder to said office.

376 (c) The Commissioner of Social Services shall seek any federal
377 matching funds available for the pool.

378 (d) When the moneys in the account have been exhausted, no
379 payments or reimbursements shall be made until moneys have been
380 deposited pursuant to subsection (b) of this section.

381 Sec. 10. Section 38a-1041 of the general statutes is repealed and the
382 following is substituted in lieu thereof (*Effective July 1, 2010*):

383 (a) There is established an Office of the Healthcare Advocate which
384 shall be within the Insurance Department for administrative purposes

385 only.

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

387 (1) Assist health insurance consumers with managed care plan
388 selection by providing information, referral and assistance to
389 individuals about means of obtaining health insurance coverage and
390 services;

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

393 (3) Provide information to the public, agencies, legislators and
394 others regarding problems and concerns of health insurance
395 consumers and make recommendations for resolving those problems
396 and concerns;

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

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

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

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

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

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

413 (10) Establish a toll-free number, or any other free calling option, to
414 allow customer access to the services provided by the Healthcare
415 Advocate;

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

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

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

422 (c) The Office of the Healthcare Advocate shall make a referral to
423 the Insurance Commissioner if the Healthcare Advocate finds that a
424 preferred provider network may have engaged in a pattern or practice
425 that may be in violation of sections 38a-226 to 38a-226d, inclusive, 38a-
426 479aa to 38a-479gg, inclusive, or 38a-815 to 38a-819, inclusive.

427 (d) The Healthcare Advocate and the Insurance Commissioner shall
428 jointly compile a list of complaints received against managed care
429 organizations and preferred provider networks and the commissioner
430 shall maintain the list, except the names of complainants shall not be
431 disclosed if such disclosure would violate the provisions of section 4-
432 61dd or 38a-1045.

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

444 accordance with the provisions of section 11-4a, on the implementation
445 of this subsection to the joint standing committees of the General
446 Assembly having cognizance of matters relating to public health and
447 insurance.

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

458 (g) The Office of the Healthcare Advocate shall administer the
459 catastrophic medical expenses pool established under section 2 of this
460 act and carry out the provisions of sections 1 to 9, inclusive, of this act,
461 with the assistance and advice of the Catastrophic Medical Expenses
462 Advisory Commission established under section 3 of this act. Said
463 office shall adopt regulations, in accordance with chapter 54, to
464 implement the provisions of sections 1 to 9, inclusive, of this act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	July 1, 2010	New section
Sec. 2	July 1, 2010	New section
Sec. 3	July 1, 2010	New section
Sec. 4	July 1, 2010	New section
Sec. 5	July 1, 2010	New section
Sec. 6	July 1, 2010	New section
Sec. 7	July 1, 2010	New section
Sec. 8	July 1, 2010	New section
Sec. 9	July 1, 2010	New section
Sec. 10	July 1, 2010	38a-1041

Statement of Legislative Commissioners:

In the last sentence of subdivision (3) of section 4, "payment of reimbursement" was changed to "payment or reimbursement" for accuracy.

INS *Joint Favorable Subst.-LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 11 \$	FY 12 \$
Comptroller	GF - Cost	Potential	Potential

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 11 \$	FY 12 \$
Various Municipalities	Cost	Potential	Potential

Explanation

This bill establishes a catastrophic medical expenses pool (a separate, non-lapsing account under the Insurance Fund) to provide payment or reimbursement for medical and related expenses incurred for a child (on or after 1/1/11) whose family meets certain income and expense thresholds. This pool is to be funded through an annual fee of \$1-per-life-covered from every insurance entity in the state and remitted to the Office of the Healthcare Advocate (OHA). Policyholders that have collected and paid this fee may then collect \$1 from each of their insured, provided that the amount they collect does not exceed the amount they paid OHA.

The state employee and retiree health plan currently covers approximately 200,000 employees, retirees, and dependents and therefore is expected to incur a potential cost of up to \$200,000 as a result of this bill. Although the state as an employer is permitted to recoup this \$1 fee from plan participants it is not clear that this fee could be recouped entirely since state employee and retiree premium share contributions are established by collective bargaining. It is also unclear whether the state's self-insured health plan would be exempt

from this health insurance mandate under federal ERISA legislation.

All municipalities offering health insurance coverage potentially may incur a cost equal to, or less than, the number of lives covered as a result of this bill, including the Municipal Employee Health Insurance Plan (MEHIP) which currently covers 44 municipalities. It is not clear that this fee could be recouped from plan participants due to collective bargaining arrangements. It is also unclear whether municipalities with self-insured health plans would be exempt from this health insurance mandate under federal ERISA legislation.

OHA will require \$170,400 in FY 11 and \$163,400 in FY 12 to administer the catastrophic medical expenses pool. Please see the table below for details.

Item	FY 11	FY 12
Insurance Program Manager	\$96,000	\$96,000
Fringe Benefits ¹	\$62,400	\$62,400
Other Expenses (advertising, telephone, etc.)	\$10,00	\$5,000
Equipment (computer, office furniture)	\$2,000	\$0
TOTAL	\$170,400	\$163,400

These administrative costs would be paid out of the catastrophic medical expenses pool account, established in the bill; thus there is no fiscal impact to OHA. After administrative costs, approximately \$2.7 million would be available in the account for payments for qualifying individuals’ medical and related expenses in FY 11 and FY 12.

The Out Years

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

¹ The fringe benefit costs for non-General Fund state employees are budgeted for directly in the affected agency’s budget. The actual fringe benefit rate for the Office of the Healthcare Advocate was 65% as of January 2010.

Sources: *Consumer Report Card on Health Insurance Carriers in Connecticut (Department of Insurance, 2009)*
United States Census Bureau

OLR Bill Analysis**sHB 5013*****AN ACT ESTABLISHING A CATASTROPHIC MEDICAL EXPENSES POOL.*****SUMMARY:**

This bill establishes (1) the Catastrophic Medical Expenses Advisory Commission and (2) a catastrophic medical expenses pool to reimburse or pay for, beginning January 1, 2011, certain medical and related expenses incurred for a child age 18 or younger when the family's expenses exceed a specified percentage of income. Under the bill, the healthcare advocate administers the pool with the commission's advice.

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, other entities issuing individual or group health insurance, and third party administrators to collect a fee of \$1 per person covered under health insurance policies and plans. It requires the social services commissioner to apply for any available federal matching funds.

The bill requires the healthcare advocate to adopt implementing regulations.

EFFECTIVE DATE: July 1, 2010

§ 3 — ADVISORY COMMISSION

The bill establishes a Catastrophic Medical Expenses Advisory Commission. Commission members include the healthcare advocate; comptroller; social services, public health, and insurance commissioners or their designees; and other members the healthcare advocate appoints. The bill requires the healthcare advocate to appoint one or more:

1. members of the Insurance and Real Estate Committee,
2. members of the general public,
3. representatives of self-insured employers,
4. representatives of the health insurance industry,
5. licensed health care providers practicing in Connecticut, and
6. senior managers or human resources directors of labor unions offering Taft-Hartley plans (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).

The bill does not specify the length of an appointee's term, how vacancies are filled, or meeting and attendance requirements.

§ 4 — HEALTHCARE ADVOCATE'S POWERS AND DUTIES

Under the bill, the healthcare advocate must develop application procedures, and the application, for seeking payment or reimbursement from the pool. He 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; and
5. methods to verify (a) previous payments to an applicant, if

necessary, (b) if services were covered by insurance or provided free of charge, and (c) that other available sources of payment have been exhausted.

The bill requires the healthcare advocate to establish an application approval process, including criteria to prioritize pool payments or reimbursements. It specifies that if the deposited fees in the account 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" (i.e., "spending down" to qualify for Medicaid (see BACKGROUND).)

The healthcare advocate 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 a 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 healthcare advocate 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 healthcare advocate 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, including contracts with licensed physicians and clinicians and people with appropriate expertise to assist the advocate in performing his or her duties;
3. accept private or federal grants for the pool and gifts, donations, or bequests, including donations of services; and
4. take any other action necessary to implement the bill.

§ 5 — PEOPLE ELIGIBLE TO APPLY TO THE POOL

Under the bill, a child or a family member on a child's behalf is eligible to apply for pool reimbursement or payment if the child:

1. is age 18 or younger;
2. is a Connecticut resident and a U.S. citizen or resident alien;
3. is covered under a health insurance policy or benefit plan (see

below);

4. is not eligible for Medicaid, HUSKY, or state-administered general assistance (SAGA) when the child incurred the medical or related expenses for which he or she wants pool reimbursement or is eligible for these benefits but is covered by a health insurance policy or benefit plan; and
5. has exhausted other payment sources and administrative remedies under the child's policy or plan.

A child is covered under a health insurance policy or benefit 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 healthcare advocate;
3. the Municipal Employee Health Insurance Plan (MEHIP);
4. a comprehensive individual or group health care plan as specified in state law; or
5. a high-deductible health plan designed to be compatible with a federally qualified medical or health savings account, if the child has exhausted the account and the family's subsequent medical and related expenses exceed specified income levels.

§ 6 — POOL REIMBURSEMENTS AND PAYMENTS

Limited Based on Family Income

The bill limits the amount the pool can pay or reimburse for a child's medical and related expenses (see Table 1). The limit is based on the amount the child's family paid in a calendar year for medical and related expenses and the family income, which is based on the

federal poverty level (FPL). (In 2010, 200% of 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. It defines “family” as a child, any siblings, and one or more (1) biological or adoptive parents, (2) legal guardians or custodians, or (3) adults with a primary responsibility for paying for a child’s medical care.

TABLE 1

<i>If a Person’s Family Income is:</i>	<i>Then Pool Payments and Reimbursements are Limited to Expenses the Person Paid in a Calendar Year that Exceed:</i>
200% FPL or less	8% of family income
> 200% FPL to 300% FPL	9% of family income
> 300% FPL to 400% FPL	10% of family income
> 400% FPL to 500% FPL	12½% of family income
> 500% FPL to 1,000% FPL	15% of family income
> 1,000% FPL to 1,500% FPL	20% of family income
> 1,500% FPL to 2,000% FPL	25% of family income
> 2,000% FPL to 2,500% FPL	30% of family income
> 2,500% 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, in a chronic and convalescent hospital, or in a nursing home, rehabilitation, transitional, or other residential facility;
2. premiums, copayments, deductibles, coinsurance, and other out-of-pocket expenses an applicant paid for, or under, a long-term care policy;
3. premiums an applicant paid for a health insurance policy or benefit plan, including a vision or dental plan;
4. items denied because the insured or enrollee failed to comply with an insurer's terms, such as network or prior authorization requirements;
5. infertility diagnosis and treatment;
6. massage services, natureopathy, and other alternative medicine treatments or services;
7. dental braces, dentures, cosmetic dental procedures, and routine dental services, including fillings, cleanings, and other prophylaxis measures;
8. vision correction services, including LASIK surgery;

9. pharmaceutical or biological products or any substance that may be lawfully sold over the counter without a prescription according to federal law;
10. vitamins or food supplements, unless prescribed for a diagnosed medical condition;
11. cosmetics or anything used or worn solely to improve appearance;
12. services, treatments, or products that are more expensive than equally effective alternatives, as determined by the healthcare advocate;
13. programs, services, or expenses the healthcare advocate chooses to exclude by regulation; and
14. items that are not cost-effective or appropriate for the child's medical condition, as determined by the healthcare advocate.

According to the bill, the healthcare advocate'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 healthcare advocate disagrees with an entity's determination, the bill permits him to be a party to an appeal the applicant may file with the entity.

§ 2 — EXPENSES ELIGIBLE FOR REIMBURSEMENT OR 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 under the child's insurance policy or benefit plan but were denied in whole or part because a policy or plan limitation was reached;

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

Limitations

The bill limits pool payment or reimbursement for (1) wheelchairs and hearing aids to once every two years and (2) eyeglass frames to \$50.

Publicly Available List

The bill requires the healthcare advocate to make publicly available a list of medical and related expenses eligible for pool reimbursement or payment. The advocate must (1) update the list whenever there is a change and (2) review the list at least annually.

Payment Not Required

The bill specifies that nothing in it is to be construed as requiring the healthcare advocate to make any payment or reimbursement to an applicant.

§ 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.

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 (1) current Medicaid and insurer rates or (2) 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 advocate establishes, if:

1. the insured's or enrollee's provider has agreed, in writing, to accept the payment as payment in full;
2. the applicable insurer, health care center (i.e., HMO), self-insured employer, insured, or enrollee provides documentation or information the healthcare advocate requests to determine the pool eligibility; 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 advocate or his or her designees deem it necessary to maintaining the child's ability to remain at home.

Reimbursement of Paid Expenses

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

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

Not Unauthorized Insurer or Preferred Provider Network

The bill specifies that, regardless of any state law, the healthcare advocate must not be deemed to be an unauthorized insurer or a preferred provider network.

§ 8 — PUBLIC ASSISTANCE

The bill deems the pool to be a public assistance program. It

specifies that the Department of Social Services (DSS) must not count a pool payment or reimbursement as income or assets for purposes of determining eligibility for state medical assistance. But any payment or reimbursement to a person who is also an applicant for Medicaid must be considered an incurred expense paid by a public assistance program and counted for purposes of reducing the applicant's excess income.

§ 9 — 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, other entities issuing individual or group insurance policies, and third party administrators for self-insured benefit plans to collect by January 1st of each year, a fee of \$1 per life covered from each policyholder or insured. They are to collect the fees at policy or plan renewal time and remit them within 30 days to the healthcare advocate for deposit into the account. A policyholder who pays the fee may collect a \$1 fee from each person insured under the policy, as long as the amount collected does not exceed the amount paid to the healthcare advocate.

Federal Matching Funds

The bill requires the DSS 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

Yea 15 Nay 4 (02/16/2010)