



General Assembly

February Session, 2010

**Raised Bill No. 5013**

LCO No. 161

\*00161\_\_\_\_\_INS\*

Referred to Committee on Insurance and Real Estate

Introduced by:  
(INS)

**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 of 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	<i>July 1, 2010</i>	New section
Sec. 2	<i>July 1, 2010</i>	New section
Sec. 3	<i>July 1, 2010</i>	New section
Sec. 4	<i>July 1, 2010</i>	New section
Sec. 5	<i>July 1, 2010</i>	New section
Sec. 6	<i>July 1, 2010</i>	New section
Sec. 7	<i>July 1, 2010</i>	New section
Sec. 8	<i>July 1, 2010</i>	New section
Sec. 9	<i>July 1, 2010</i>	New section
Sec. 10	<i>July 1, 2010</i>	38a-1041

**Statement of Purpose:**

To create a catastrophic medical expenses pool to help defray children's medical and related expenses that exceed a threshold percentage of family income for children who are insured but have catastrophic medical expenses.

*[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]*