
OLR Bill Analysis

sSB 425

AN ACT CONCERNING A BASIC HEALTH PROGRAM.

SUMMARY:

This bill requires the special advisor to the governor on healthcare reform (hereafter referred to as “special advisor”), in consultation with the Department of Social Services (DSS) commissioner, to establish and implement a Basic Health Program (BHP) in accordance with the 2010 federal Patient Protection and Affordable Care Act. She must do this by January 1, 2014, and within available appropriations.

Under the bill, the program provides subsidized health insurance to individuals (1) with incomes up to 200% of the federal poverty level (FPL), (2) under age 65, and (3) who do not qualify for Medicaid and otherwise meet the BHP program’s federal eligibility criteria. Individuals in the BHP would be ineligible to obtain health insurance through the state’s health insurance exchange, which the state must establish by 2014 (see BACKGROUND). The federal government largely subsidizes the BHP’s costs.

The bill:

1. requires the BHP to offer Medicaid-equivalent benefit levels and cost-sharing limits, unless it will cost the state more than it receives in federal subsidies;
2. moves certain HUSKY A adult recipients into the BHP provided they maintain the same benefit levels and cost-sharing limits (currently they pay no cost sharing);
3. requires the special advisor to (a) submit a BHP implementation plan to the Appropriations, Human Services, and Public Health committees for their approval and (b) take all necessary steps to

maximize federal funding and seek any necessary federal approval in connection with establishing the BHP; and

4. establishes a separate, nonlapsing General Fund account for the federal BHP subsidies.

The bill also requires the DSS commissioner to use (1) 50% of the anticipated savings from moving the HUSKY A adults into the BHP in FY 14 and FY 15 and (2) any BHP federal subsidies the state receives that exceed the cost of providing Medicaid-equivalent coverage to increase BHP provider reimbursement rates.

EFFECTIVE DATE: Upon passage

BASIC HEALTH PROGRAM (BHP)

Program Benefits and Cost Sharing (§ 1(b))

The bill requires the BHP to provide the same benefits, cost-sharing limits, and other consumer safeguards that apply to Medicaid recipients, unless the special advisor determines that doing so will cost more than the federal subsidies available to the state to pay for the BHP.

If the special advisor makes such a determination, she must, in consultation with the DSS commissioner, develop and submit a plan that maximizes benefits and minimizes cost sharing in order to run the BHP within available federal subsidies and not use any state funds. The plan must be submitted in accordance with the bill's reporting requirements (see § 2).

BHP Plan (§ 2)

The bill requires the special advisor, in consultation with the DSS commissioner, to submit a plan to establish and implement the BHP to the Appropriations, Human Services, and Public Health committees by November 1, 2012.

The committees must hold a public hearing on the plan within 30 days of receiving it. At the hearing's conclusion, they must advise the special advisor of their approval, denial, or modification of the plan.

If the committees do not concur, the bill requires their chairpersons to appoint a conference committee composed of three members from each committee. At least one member from each committee must be from the minority party.

The conference committee must report to each standing committee, which must vote to accept or reject the report without any amendments. If any committee rejects the conference committee's report, it must notify the special advisor and the plan is deemed approved. (It appears the only way the plan can be rejected is if all three committees vote to do so.) If the committees accept the report, the Appropriations Committee must advise the special advisor of their decision to approve, deny, or modify the plan within the 30-day period, otherwise the plan is deemed approved.

The bill specifies that any plan the special advisor submits to the federal government must be in accordance with the committees' actions.

Eligibility for HUSKY A Adults (§ 3)

Starting January 1, 2014, the bill eliminates HUSKY A eligibility for caretaker adults with income over 133% of the FPL. This in effect makes adults with incomes between 133% and 200% of the FPL who would otherwise qualify for HUSKY A eligible for the BHP. (Under current law, HUSKY A is available to caretaker adults of children receiving HUSKY A with family income up to 185% of the FPL.)

The bill expressly states that this reduction in income limit occurs only if the state implements a BHP that offers the same benefits, cost-sharing limits, and other consumer safeguards offered under Medicaid.

Use of HUSKY A Adult Savings (§ 4)

For FY 14 and FY 15, the bill requires 50% of any savings from limiting the income eligibility for HUSKY A caretaker adults to 133% of the FPL to be used to increase BHP provider reimbursement rates. Rates must be increased to maximize access to needed health care

services.

Use of Excess Federal Subsidies (§ 1(c))

To the extent federal law allows, the bill requires any federal subsidies the state receives for the BHP that exceed the cost of providing the Medicaid-equivalent coverage to BHP enrollees to be used to increase BHP provider reimbursement rates. The DSS commissioner, in consultation with the special advisor, must increase the rates in a way that maximizes access to needed health care services.

The bill requires the commissioner, in consultation with the special advisor, to establish a committee to make recommendations to (1) keep provider rates competitive, (2) provide payment incentives to increase access to primary care offices as an alternative to emergency room care, and (3) streamline paperwork. The committee consists of DSS and Office of Health Reform and Innovation (OHRI) representatives and health care providers serving Medicaid and BHP enrollees.

BHP Account (§ 5)

The bill establishes a BHP account as a separate, non-lapsing account in the General Fund to hold any moneys the law requires to be deposited into it. The DSS commissioner, in consultation with the special advisor, must spend the funds to operate the BHP, in accordance with federal law.

BACKGROUND

Related Bill

sHB 5450 (File 315), favorably reported by the Human Services Committee, similarly requires the DSS commissioner to establish and implement a BHP by January 1, 2014.

BHP

Section 1331 of the 2010 federal Patient Protection and Affordable Care Act (PPACA, PL 111-148) allows states, beginning in 2014, to establish BHPs for individuals (1) ineligible for Medicaid, (2) under age 65, (3) with household income between 133% and 200% of the FPL (individuals with incomes under 133% of the FPL qualify for

Medicaid), and (4) ineligible for minimal essential health care coverage (e.g., State Children’s Health Insurance Program (HUSKY B in Connecticut)) or who cannot afford their employer’s coverage.

The federal law imposes cost-sharing limits and requires that state BHPs provide benefits at least as rich as those in the state’s “essential health benefits package” available to someone purchasing insurance through its health insurance exchange.

States that operate a BHP are eligible for federal subsidies equaling 95% of the premium tax credits and cost-sharing reductions that the federal government would have spent if BHP enrollees had received their assistance when enrolling in an exchange health plan. (Connecticut receives a 50% federal match for its health care expenditures under Medicaid.)

The law requires states to establish funds into which the federal subsidies are deposited and can be used only to reduce BHP enrollees’ premiums and cost sharing or to provide them with additional benefits (42 § USC 18051).

Health Insurance Exchange

A health insurance exchange is a set of state-regulated and standardized plans from which individuals may purchase health insurance eligible for federal subsidies. Under the PPACA, all exchanges must be fully certified and operational by January 1, 2014.

Federal Poverty Levels (FPL)

The following are the 2012 FPLs for family sizes of one to three people.

Family Size	100% of FPL	133% of FPL	200% of FPL
1	\$11,170	\$14,856	\$22,340
2	\$15,130	\$20,123	\$30,260
3	\$19,090	\$25,390	\$38,180

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute

Yea 18 Nay 10 (03/29/2012)