



General Assembly

February Session, 2012

Amendment

LCO No. 4640

HB0545004640HDO

Offered by:

REP. TERCYAK, 26th Dist.
SEN. MUSTO, 22nd Dist.
REP. MORRIS, 140th Dist.

SEN. COLEMAN, 2nd Dist.
REP. RITTER E., 38th Dist.
SEN. GERRATANA, 6th Dist.

To: Subst. House Bill No. 5450

File No. 315

Cal. No. 256

"AN ACT ESTABLISHING A BASIC HEALTH PROGRAM."

1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

3 "Section 1. (NEW) (*Effective from passage*) (a) For purposes of this
4 section, sections 2 and 3 of this act and sections 17a-22h and 17b-261 of
5 the general statutes, as amended by this act:

6 (1) "Affordable Care Act" means the Patient Protection and
7 Affordable Care Act, P.L. 111-148, as amended by the Health Care and
8 Education Reconciliation Act, P.L. 111-152, as both may be amended
9 from time to time, and any regulations adopted under said acts;

10 (2) "Basic Health Program" means a health insurance plan
11 established in accordance with Section 1331 of the Affordable Care Act;

12 (3) "Eligible enrollee" means an individual under sixty-five years of

13 age with income not exceeding two hundred per cent of the federal
14 poverty level who is ineligible for medical assistance pursuant to Title
15 XIX of the Social Security Act but otherwise eligible for medical
16 assistance under Section 1331 of the Affordable Care Act; and

17 (4) "Special advisor" means the special advisor to the Governor on
18 Healthcare Reform and director of the Office of Health Reform and
19 Innovation, as established in section 19a-724 of the general statutes.

20 (b) The special advisor shall convene a working group on or before
21 May 15, 2012, to study the feasibility of establishing a basic health
22 program in accordance with Section 1331 of the Affordable Care Act.
23 The working group shall consist of (1) the special advisor or the special
24 advisor's designee; (2) the Commissioner of Social Services or the
25 commissioner's designee; (3) the Secretary of the Office of Policy and
26 Management or the secretary's designee; (4) the state Healthcare
27 Advocate or the Healthcare Advocate's designee; (5) the president or
28 chief executive officer of a federally-qualified health center appointed
29 by the Community Health Center Association of Connecticut; (6) a
30 primary care provider appointed by the Connecticut Chapter of the
31 American College of Physicians; (7) a representative of the entity with
32 whom the Department of Social Services contracts for administrative
33 services for the state's medical assistance program; (8) one
34 representative of Connecticut hospitals, appointed by the Connecticut
35 Hospital Association; (9) the two board members of the Connecticut
36 Health Insurance Exchange representing consumers, or their
37 designees; (10) the member of the Connecticut Health Insurance
38 Exchange with expertise in health insurance coverage appointed by the
39 chair of the health insurance exchange; (11) a representative of the
40 consumer advisory board of the Office of Health Reform and
41 Innovation, appointed by the special advisor; and (12) one advocate for
42 adults with psychiatric disabilities appointed by the Behavioral Health
43 Partnership Oversight Council. Upon the request of the working
44 group, the Connecticut Health Insurance Exchange shall promptly
45 share research and actuarial findings that the working group
46 determines are relevant to its duties under subsections (e) and (f) of

47 this section, as allowable under federal law.

48 (c) The staff of the Office of Health Reform and Innovation shall
49 provide administrative services to the working group, within existing
50 appropriations.

51 (d) On or before October 1, 2012, or sixty days after federal
52 regulations or guidance is issued concerning the federal subsidies
53 available to fund a basic health program, which ever is later, the
54 Department of Social Services shall provide information to the
55 working group on the estimated cost of providing benefits under the
56 basic health program.

57 (e) Not later than thirty days after receiving (1) the information
58 described in subsection (d) of this section; (2) any necessary
59 information shared by the Connecticut Health Insurance Exchange;
60 and (3) guidance concerning federal subsidies from the United States
61 Department of Health and Human Services, the working group shall
62 determine whether the available subsidies will cover the costs of a
63 basic health program that includes the same benefits, program
64 administration, limits on cost sharing and other consumer safeguards
65 that apply to medical assistance provided in accordance with Title XIX
66 of the Social Security Act. If the working group determines that the
67 federal subsidies do not cover the cost of such benefits, program
68 administration, limits on cost sharing and other consumer safeguards,
69 the working group shall determine whether a plan can be designed
70 within available federal funds to meet the needs of eligible enrollees,
71 as defined in subdivision (3) of subsection (a) of this section.

72 (f) The working group shall recommend to the Connecticut Health
73 Insurance Exchange Board and to the joint standing committees of the
74 General Assembly having cognizance of matters relating to
75 appropriations and the budgets of state agencies, public health and
76 human services that the basic health program not be established if: (1)
77 A plan cannot be designed within federal funds to meet the needs of
78 eligible enrollees; (2) the majority of eligible enrollees are more likely

79 to register for the Connecticut Health Insurance Exchange; (3) the basic
80 health program's provider network is not expected to meet standards
81 for access to medical assistance as provided under Title XIX of the
82 Social Security Act; (4) the establishment of a state basic health
83 program will leave too few enrollees for the Connecticut Health
84 Insurance Exchange to be fiscally viable; or (5) federal requirements for
85 the basic health program do not permit the plan to be offered through
86 the administrative services organization infrastructure and provider
87 network for the medical assistance program administered by the
88 Department of Social Services and the working group concludes that
89 there is no viable alternative administrative structure.

90 Sec. 2. (*Effective from passage*) (a) Not later than January 1, 2013, the
91 working group established in accordance with section 1 of this act, in
92 consultation with the Commissioner of Social Services, shall submit the
93 working group's recommendation and any applicable plan regarding
94 the establishment and implementation of a basic health program to the
95 Connecticut Health Insurance Exchange and to the joint standing
96 committees of the General Assembly having cognizance of matters
97 relating to human services, public health, appropriations and the
98 budgets of state agencies.

99 (b) Not later than sixty days after the date of receipt of such
100 recommendation and applicable plan, said joint standing committees
101 shall hold a public hearing. At the conclusion of such public hearing,
102 said joint standing committees shall advise the special advisor of their
103 approval, denial or modifications, if any, of the working group's plan.
104 If the plan is rejected by the committees, the committees may request
105 that the working group submit a revised plan for consideration by the
106 committees within forty-five days. If the plan is approved or modified,
107 the special advisor shall submit the committees' recommendations to
108 the Governor for review and approval or denial. If the Governor
109 denies the plan, it will not be submitted to the federal government.

110 (c) If the joint standing committees do not concur, the committee
111 chairpersons shall appoint a committee of conference which shall be

112 composed of three members from each joint standing committee
113 specified in subsection (a) of this section. At least one member
114 appointed from each joint standing committee shall be a member of
115 the minority party. The report of the committee of conference shall be
116 made to each joint standing committee specified in subsection (a) of
117 this section, which shall vote to accept or reject the report. The report
118 of the committee of conference may not be amended. If a joint standing
119 committee rejects the report of the committee of conference, such joint
120 standing committee shall notify the special advisor of the rejection and
121 the working group's plan shall be deemed approved. Once the report
122 is deemed approved, the committee having cognizance of matters
123 relating to human services shall submit the plan to the Governor for
124 approval or denial. If the joint standing committees accept the report,
125 the committee having cognizance of matters relating to human services
126 shall notify the special advisor of their approval, denial or
127 modifications, if any, of the plan. If the joint standing committees do
128 not so notify the special advisor during such thirty-day period, the
129 plan shall be deemed approved. Any plan submitted by the
130 Commissioner of Social Services to the federal government pursuant to
131 this section shall be (1) in accordance with the approval or
132 modifications, if any, of the joint standing committees of the General
133 Assembly having cognizance of matters relating to human services,
134 public health, appropriations and the budgets of state agencies, and (2)
135 approved by the Governor.

136 Sec. 3. (NEW) (*Effective from passage*) (a) The Commissioner of Social
137 Services shall accept and implement the recommendations issued by
138 the working group, as approved pursuant to section 2 of this act, for
139 coverage in the program beginning on or after January 1, 2014, in
140 accordance with Section 1331 of the federal Affordable Care Act.

141 (b) The Commissioner of Social Services shall take all necessary
142 actions to maximize federal funding and seek any necessary approvals
143 from the federal government in connection with the establishment of a
144 basic health program.

145 Sec. 4. Subsection (a) of section 17b-261 of the 2012 supplement to
146 the general statutes is repealed and the following is substituted in lieu
147 thereof (*Effective from passage*):

148 (a) Medical assistance shall be provided for any otherwise eligible
149 person whose income, including any available support from legally
150 liable relatives and the income of the person's spouse or dependent
151 child, is not more than one hundred forty-three per cent, pending
152 approval of a federal waiver applied for pursuant to subsection (e) of
153 this section, of the benefit amount paid to a person with no income
154 under the temporary family assistance program in the appropriate
155 region of residence and if such person is an institutionalized
156 individual as defined in Section [1917(c)] 1917 of the Social Security
157 Act, 42 USC [1396p(c)] 1396p(h)(3), and has not made an assignment or
158 transfer or other disposition of property for less than fair market value
159 for the purpose of establishing eligibility for benefits or assistance
160 under this section. Any such disposition shall be treated in accordance
161 with Section 1917(c) of the Social Security Act, 42 USC 1396p(c). Any
162 disposition of property made on behalf of an applicant or recipient or
163 the spouse of an applicant or recipient by a guardian, conservator,
164 person authorized to make such disposition pursuant to a power of
165 attorney or other person so authorized by law shall be attributed to
166 such applicant, recipient or spouse. A disposition of property ordered
167 by a court shall be evaluated in accordance with the standards applied
168 to any other such disposition for the purpose of determining eligibility.
169 The commissioner shall establish the standards for eligibility for
170 medical assistance at one hundred forty-three per cent of the benefit
171 amount paid to a family unit of equal size with no income under the
172 temporary family assistance program in the appropriate region of
173 residence. Except as provided in section 17b-277, the medical
174 assistance program shall provide coverage to persons under [the age
175 of] nineteen years of age with family income up to one hundred
176 eighty-five per cent of the federal poverty level without an asset limit
177 and to persons under [the age of] nineteen years of age and their
178 parents and needy caretaker relatives, who qualify for coverage under

179 Section 1931 of the Social Security Act, with family income up to one
180 hundred eighty-five per cent of the federal poverty level without an
181 asset limit. On or after January 1, 2014, and contingent upon the
182 implementation of a basic health program with the same benefits,
183 limits on cost sharing and other consumer safeguards provided under
184 Title XIX of the Social Security Act, coverage shall be provided to
185 parents and needy caretaker relatives of persons under nineteen years
186 of age, who qualify for coverage under Section 1931 of the Social
187 Security Act, with family income up to one hundred thirty-three per
188 cent of the federal poverty level without an asset limit. Such levels
189 shall be based on the regional differences in such benefit amount, if
190 applicable, unless such levels based on regional differences are not in
191 conformance with federal law. Any income in excess of the applicable
192 amounts shall be applied as may be required by said federal law, and
193 assistance shall be granted for the balance of the cost of authorized
194 medical assistance. The Commissioner of Social Services shall provide
195 applicants for assistance under this section, at the time of application,
196 with a written statement advising them of (1) the effect of an
197 assignment or transfer or other disposition of property on eligibility
198 for benefits or assistance, (2) the effect that having income that exceeds
199 the limits prescribed in this subsection will have with respect to
200 program eligibility, and (3) the availability of, and eligibility for,
201 services provided by the Nurturing Families Network established
202 pursuant to section 17b-751b. Persons who are determined ineligible
203 for assistance pursuant to this section shall be provided a written
204 statement notifying such persons of their ineligibility and advising
205 such persons of the availability of HUSKY Plan, Part B health
206 insurance benefits.

207 Sec. 5. Subsection (a) of section 17a-22h of the general statutes is
208 repealed and the following is substituted in lieu thereof (*Effective from*
209 *passage*):

210 (a) The Commissioners of Social Services, Children and Families,
211 and Mental Health and Addiction Services shall develop and
212 implement an integrated behavioral health service system for HUSKY

213 Plan Parts A and B members and children enrolled in the voluntary
 214 services program operated by the Department of Children and
 215 Families and may, at the discretion of the commissioners, include: (1)
 216 Other children, adolescents and families served by the Department of
 217 Children and Families or the Court Support Services Division of the
 218 Judicial Branch; (2) Medicaid recipients who are not enrolled in
 219 HUSKY Plan Part A; [and] (3) Charter Oak Health Plan members; and
 220 (4) on or after January 1, 2014, enrollees in the basic health program,
 221 contingent on the establishment of the basic health program. The
 222 integrated behavioral health service system shall be known as the
 223 Behavioral Health Partnership. The Behavioral Health Partnership
 224 shall seek to increase access to quality behavioral health services by:
 225 (A) Expanding individualized, family-centered and community-based
 226 services; (B) maximizing federal revenue to fund behavioral health
 227 services; (C) reducing unnecessary use of institutional and residential
 228 services for children and adults; (D) capturing and investing enhanced
 229 federal revenue and savings derived from reduced residential services
 230 and increased community-based services for HUSKY Plan Parts A and
 231 B recipients; (E) improving administrative oversight and efficiencies;
 232 and (F) monitoring individual outcomes and provider performance,
 233 taking into consideration the acuity of the patients served by each
 234 provider, and overall program performance."

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	New section
Sec. 2	<i>from passage</i>	New section
Sec. 3	<i>from passage</i>	New section
Sec. 4	<i>from passage</i>	17b-261(a)
Sec. 5	<i>from passage</i>	17a-22h(a)