



General Assembly

February Session, 2012

Amendment

LCO No. 4816

HB0545004816HDO

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; (12) one advocate for
42 adults with psychiatric disabilities appointed by the Behavioral Health
43 Partnership Oversight Council; and (13) one member appointed by the
44 Governor. Upon the request of the working group, the Connecticut
45 Health Insurance Exchange shall promptly share research and
46 actuarial findings that the working group determines are relevant to its

47 duties under subsections (e) and (f) of this section, as allowable under
48 federal law.

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

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

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

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

79 eligible enrollees; (2) the majority of eligible enrollees are more likely
80 to register for the Connecticut Health Insurance Exchange; (3) the basic
81 health program's provider network is not expected to meet standards
82 for access to medical assistance as provided under Title XIX of the
83 Social Security Act; (4) the establishment of a state basic health
84 program will leave too few enrollees for the Connecticut Health
85 Insurance Exchange to be fiscally viable; or (5) federal requirements for
86 the basic health program do not permit the plan to be offered through
87 the administrative services organization infrastructure and provider
88 network for the medical assistance program administered by the
89 Department of Social Services and the working group concludes that
90 there is no viable alternative administrative structure.

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

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

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

140 Sec. 3. (NEW) (*Effective from passage*) (a) The Commissioner of Social
141 Services shall accept and implement the plan, as approved pursuant to
142 section 2 of this act, for coverage in the program beginning on or after
143 January 1, 2014, in accordance with Section 1331 of the federal
144 Affordable Care Act.

145 (b) The Commissioner of Social Services shall take all necessary
146 actions to maximize federal funding and seek any necessary approvals

147 from the federal government in connection with the establishment of a
148 basic health program.

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

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

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

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

214 (a) The Commissioners of Social Services, Children and Families,

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

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| 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) |