



STATE OF CONNECTICUT

OFFICE OF POLICY AND MANAGEMENT

TESTIMONY PRESENTED TO THE HUMAN SERVICES COMMITTEE

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Testimony Supporting House Bill No. 6367

AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HUMAN SERVICES PROGRAMS

Good morning, Senator Slossberg, Representative Abercrombie and distinguished members of the Human Services Committee. Thank you for the opportunity to offer testimony on House Bill No. 6367, An Act Implementing the Governor's Budget Recommendations for Human Services Programs.

The initiatives in this bill will result in: (1) savings of \$113.6 million in FY 14 and \$207.0 million in FY 15; (2) costs of \$51.6 million in FY 14 and \$301.0 million in FY 15; and (3) additional revenue of \$7.0 million in each year of the biennium. For your reference, I have included an explanation of the various sections of the bill at the end of my testimony. For today, I would like to focus my remarks on the hospital reductions and the changes in the budget related to the Health Insurance Exchange.

Sections 11 and 12 of the bill relate to the supplemental payments to hospitals as a result of the transition to an administrative services organization (ASO) in January 2012. In the process of converting from managed care to an ASO, the department developed rate melds to integrate the different rate structures that existed under the managed care organizations and the fee-for-service payment model under the ASO. As expenses have increased significantly under the new ASO payment structure, this proposal, which was adopted by the legislature in the December special session (with an end date of June 30, 2013), mitigates these increases by eliminating funding for the ASO transition supplemental payments for outpatient services, CCMC's physician group and inpatient behavioral health services. The Governor's budget reflects savings of \$23.5 million in FY 14 and FY 15. It should be noted that not all categories of transitional payments have been eliminated - the Governor's budget includes \$30 million in payments for inpatient services in each year of the biennium.

In total, the Governor's budget: (1) annualizes the hospital reductions adopted by the legislature in the December special session for savings of \$196.1 million in each year of the biennium; and (2) includes additional hospital savings of \$12.0

million in FY 14 and \$146.2 million in FY 15, for total savings of \$208.1 million in FY 14 and \$342.3 million in FY 15.

These reductions include the elimination of certain ASO transitional payments noted above as well as adjustments to funding under the Disproportionate Share Hospital account (\$134.2 million in FY 14 and \$268.5 million in FY 15) and the enhanced funding for hospitals (\$50.4 million in FY 14 and FY 15). A user fee on hospitals was reinstated effective July 1, 2011. Prior to the deficit mitigation plan, the revenue gained from the user fee assessment, as well as any federal dollars gained from that initial federal claiming, was to be redistributed to the hospitals in the form of disproportionate share hospital (DSH) payments and supplemental Medicaid payments. For FY 13, hospitals were to be assessed a user fee of \$349.1 million while receiving a total of \$399.5 million in DSH and Medicaid payments, which would have allowed the hospitals, in the aggregate, to have a net gain of \$50.4 million. This enhanced funding is eliminated. In addition, funding under the DSH account is reduced by 50% in FY 14 and 100% in FY 15. Because federal law requires states to have a DSH program, \$20 million is transferred in FY 15 from the hospital supplemental fund under Medicaid to a new line item under Medicaid.

The approval of the Medicaid expansion for Low-Income Adults (LIA) in June 2010 resulted in much higher reimbursement to hospitals than was previously available to them under the State Administered General Assistance (SAGA) program. SAGA medical payments (inpatient and outpatient) were slated to be capped at \$66.3 million in FY 11 and were generally increased about 5% a year; behavioral health rates were significantly below Medicaid rates and were expected to be \$20.4 million in FY 11. Under LIA, total reimbursements to hospitals have increased to \$331.4 million in FY 12 and are expected to exceed \$400 million in FY 13.

Hospital expenditures will continue to increase over the biennium, particularly with the Medicaid expansion under LIA, which will increase eligibility from 55% to 133% of the federal poverty level beginning January 1, 2014. It is also worth noting that with the increase in the number of insured beginning in 2014 and the corresponding reduction in the level of uncompensated care that will need to be provided by the nation's hospitals, federal disproportionate share hospital payments to states will be significantly phased down under the Affordable Care Act beginning in federal fiscal year 2014.

Projected Hospital Expenditures (in billions)

	FY 13			FY 14			FY 15		
	Before Reductions	After Reductions	Percent Change	Before Reductions	After Reductions	Percent Change	Before Reductions	After Reductions	Percent Change
Medicaid*	\$1.580	\$1.543	-2%	\$1.650	\$1.576	-4%	\$1.810	\$1.736	-4%
DSH	0.268	0.201	-25%	0.268	0.134	-50%	0.268	-	-100%
Total	\$1.848	\$1.744	-6%	\$1.918	\$1.710	-11%	\$2.078	\$1.736	-16%

* Includes DMHAS' expenditures for LIA

The Affordable Care Act will expand health coverage to more of Connecticut's residents, presenting both fiscal and programmatic challenges and opportunities. Connecticut took advantage of the option offered the states under the Act to cover low-income childless adults under Medicaid effective April 1, 2010. In June 2010, Connecticut gained approval from the federal government to expand Medicaid coverage to an estimated 45,000 low-income adults who had been enrolled in a more limited benefit package under the former SAGA program. The number of eligible individuals enrolled in the Medicaid for Low-Income Adults program far exceeded expectations and, as of January 2013, there were 87,307 individuals enrolled in LIA. Beginning January 1, 2014, states can opt to provide Medicaid coverage to all childless adults up to 133% of the federal poverty level and receive full federal reimbursement. Section 20 of this bill takes advantage of this opportunity by extending Medicaid benefits under LIA to individuals with income between 55% and 133% of the federal poverty level. The costs of the Medicaid expansion, which is projected at \$52 million in FY 14, \$301 million in FY 15 and \$398 million in FY 16, will be 100% reimbursed by the federal government through 2016, and will then be adjusted incrementally downward to a 90% reimbursement rate by 2020.

The Affordable Care Act also creates state-based Health Insurance Exchanges, which allow individuals and small businesses to purchase health insurance coverage. Lower income households purchasing health insurance through the Exchange will qualify for significant federal subsidies lowering the costs associated with obtaining and maintaining comprehensive health insurance coverage beginning January 1, 2014. These federal subsidies will include advanced premium tax credits to reduce the monthly cost of health insurance premiums as well as additional cost sharing reductions lowering the out-of-pocket, point-of-service costs for obtaining medical care and/or prescription drugs. Greater access to health insurance will continue to reduce the state's uncompensated care costs.

Significant barriers to accessing affordable health care are removed with the expansion of health care coverage under Medicaid for individuals up to 133% of the federal poverty level, the availability of insurance coverage through the Exchange, and the federal tax credits that reduce premium costs, as well as reduced cost sharing for low-income individuals. In addition to the obvious benefits to the health of Connecticut residents, this expanded coverage, and the resulting reduction in the uninsured population in Connecticut beginning in calendar year 2014, provides savings and program realignment opportunities.

For example, the Charter Oak Health Plan was established to assist those who would not otherwise have access to affordable health insurance. With the changes under the Affordable Care Act, the previous barriers to access affordable health care are removed and, as a result, section 54 of this bill eliminates coverage under the Charter oak Health Plan effective January 1, 2014.

Similarly, sections 21 through 24 transition coverage for certain adults to the Exchange, specifically clients enrolled in ConnPACE and adults under HUSKY A with income over 133% of the federal poverty level effective January 1, 2014.

These changes are expected to result in savings of \$5.8 million in FY 14 and \$59.1 million in FY 15. Coverage for pregnant women and children enrolled in HUSKY A will not be impacted by these changes.

In conclusion, in the face of rising Medicaid costs and growing caseloads, the Governor's budget takes advantage of savings opportunities under the Affordable Care Act, allowing the state's limited resources to be directed towards maintaining critical services. In addition, the changes proposed by Governor Malloy will strengthen the viability and sustainability of the Health Insurance Exchange - helping to ensure that Connecticut's residents have access to health care in the years to come.

I would again like to thank the committee for the opportunity to present this testimony. I respectfully request that the Committee support this bill and I would be happy to answer any questions you may have on these sections or any other sections of the bill.

Section-by-Section Explanation. House Bill No. 6367 makes the following changes:

Section 1. Incentivize Use of Agency Teachers for Visually-Impaired Students.

Under current statute, school districts may seek reimbursement from the Department of Rehabilitation Services for the cost of the teachers they employ or contract with to teach the blind students in their district. This bill eliminates the reimbursement to school districts for this purpose. Savings of \$1.1 million in each year of the biennium are anticipated.

Section 2. Restructure Assistive Technology Revolving Fund. This bill modifies the Assistive Technology Revolving Fund by extending loans to senior citizens and family members, extending the terms of the loans to up to ten years and establishing a fixed interest rate, not to exceed six percent. The bill also allows the Department of Rehabilitation Services to implement a reasonable fee on the assistive technology evaluation and training services for users and providers. Any additional revenue as a result of this section is expected to be nominal.

Sections 3 - 5. Maximize Revenue for Services to Children Over the Age of 18.

To ensure their future success and stability as they enter adulthood, the Department of Children and Families provides a variety of supportive services to clients over the age of 18 who have been in the department's care. Although DCF provides these supports, the state has not sought federal reimbursement due to administrative responsibilities that are necessary to obtain the reimbursement, including an annual court hearing and determination for each case. By modifying the definition of "child" to reflect the department's current practice concerning the provision of services to young adults, this bill will facilitate the state's claiming of additional federal Title IV-E reimbursements for services provided to these young adults. Additional revenue of \$7.0 million in

each year of the biennium is anticipated.

Section 6. Maintain Current Rates for Nursing Homes. Under current statute, DSS is required to rebase nursing home rates no more than once every two years and no less than once every four years. The current services budget includes a rate increase of 4.7% in FY 14 to reflect the rebasing of rates. To comply with DSS' regulations, the current services budget also includes a 2.0% inflationary adjustment in FY 15. This bill eliminates these increases over the biennium. Even with this bill, Connecticut's rates will remain one of the highest in the country. Savings of \$53.4 million in FY 14 and \$81.0 million in FY 15 are anticipated.

Section 7. Maintain Current Rates for Intermediate Care Facilities. To comply with DSS' regulations, the current services budget includes a 2.2% increase in FY 14 and a 2.0% increase in FY 15 for intermediate care facilities for those with developmental disabilities. This bill eliminates these increases over the biennium. Savings of \$1.4 million in FY 14 and \$2.7 million in FY 15 are anticipated.

Sections 8 and 9. Maintain Current Rates for Boarding Homes. Under current statute, DSS is required to annually determine rates for various boarding homes. Per DSS' regulations, boarding home rate increases are based on actual cost reports submitted by facilities, barring any legislation to remove rate increases for a particular fiscal year. Under the normal rate calculation structure, these homes would have received increases of 2.0%. This bill eliminates these increases over the biennium. Savings of \$2.3 million in FY 14 and \$4.6 million in FY 15 are anticipated.

Sections 10 and 11. Implement Hospital Payment Reform. In 1982, Congress passed the Tax Equity and Fiscal Responsibility Act (TEFRA). One of the provisions in TEFRA was the establishment of a prospective payment system for hospitals which was initially applied to Medicare and subsequently adopted by state Medicaid programs. In the years following the passage of TEFRA, Medicare and most other state Medicaid programs have migrated to a prospective payment system based on diagnosis related groups (DRGs). Whereas TEFRA cost settlement does not distinguish between the rate of reimbursement for a one-day admission or a month-long stay, the DRG system calculates rates for each category of admission based on an algorithm that calculates the rates for delivering inpatient care to diagnosis groups of similar intensity and costs. Due to the shift from inpatient care to less costly ambulatory care, Congress directed Medicare in 1997 to develop an outpatient prospective payment system. In 2000, Medicare implemented the Ambulatory Payment Classification (APC) system for outpatient hospital reimbursement. This system is similar to the inpatient DRG system in that it provides a prospective payment but unlike DRG, APC is based on visit complexity, as measured by procedures.

By replacing the department's current method of reimbursement with DRGs for inpatient services and APC for outpatient services, this bill will result in:

1. Greater administrative simplification for both hospital providers and DSS

as a result of mirroring Medicare's cost reporting reimbursement policies and procedures;

2. Greater accuracy in targeting reimbursement amounts to those cases with similar levels of costs and complexity; and
3. Greater ability to partner with Medicare and other private sector payers in developing innovative reimbursement strategies that reward improved quality as opposed to greater quantity of care.

In addition, pursuant to the Affordable Care Act, DSS is required to convert from the current International Classifications of Diseases (ICD), ninth revision, medical code set to the updated ICD, tenth revision. The tenth revision modifies code groupings and doubles the number of codes due to a much greater degree of specificity. To maximize the efficiency in the move to a DRG / APC system, the changes will occur in tandem with the conversion to ICD-10 and other payment reform efforts under the Affordable Care Act. This bill is limited to the adoption of the Medicare methodology and the latest ICD revision. It does not propose parity with Medicare rates or increases in overall expenditures. There is no fiscal impact associated with these sections.

Note: A technical correction is required in section 11. On line 792, "and" should be replaced with "or".

Sections 11 through 14. Eliminate ASO Transition Supplemental Payments. In the process of converting from managed care to an administrative services organization (ASO), the department developed rate melds to integrate the different rate structures that existed under the managed care organizations and the fee-for-service payment model under the ASO. As expenses have increased significantly under the new ASO payment structure, this proposal, which was adopted by the legislature in the December special session (with an end date of June 30, 2013), mitigates these increases by eliminating funding for the ASO transition supplemental payments for outpatient services, CCMC's physician group and inpatient behavioral health services. Savings of \$23.5 million in FY 14 and FY 15 are anticipated.

Section 15. Disproportionate Share Hospital Funding - Technical Correction. This section clarifies that the department's disproportionate share hospital payments are made on a quarterly basis, not monthly. There is no fiscal impact associated with this section.

Section 16. Restructure Requirements for Hospice and Medical Interpreters Services. This section of the bill implements two provisions included in the Governor's budget:

1. **Reduce Reimbursement for Hospice Services Provided in Institutions.** DSS provides a hospice benefit to clients who are institutionalized. For these clients, the department - prior to the changes adopted by the legislature in the December special session - paid the hospice agency 100% of the facility per diem and the hospice agency passed this on to the facility as payment for room and board services (the department also pays the hospice agency a separate rate for nursing care). Recognizing the

overlap in the services provided by the facility and the hospice agency, federal statute allows Medicaid programs to reimburse the facility component at 95% of the facility per diem rate when the client has elected hospice. Under this bill, the facility per diem payment for hospice services is reduced from 100% to 95% of the facility's rate. Savings of \$1.9 million in FY 14 and \$2.0 million in FY 15 are anticipated.

2. Provide Medical Interpreter Services under Medicaid through the ASO. Current statute requires DSS to amend the Medicaid state plan to include foreign language interpreter services provided to any beneficiary with limited English proficiency as a covered service under the Medicaid program not later than July 1, 2013. With the conversion from managed care to an ASO structure, the medical ASO now provides interpreting services. As a result, this bill eliminates the requirement that DSS implement the use of medical billing codes for foreign language interpreter services as it is no longer needed. It should be noted that the current structure allows the state to maximize federal reimbursement since the ASO's expenditures can be claimed as an administrative service with 75% federal reimbursement as opposed to the 50% reimbursement that would be available if DSS implemented the program in the manner required under statute. Savings of \$7.5 million in FY 14 and \$8.2 million in FY 15 are anticipated.

Section 17. Restructure Pharmacy Reimbursement. This section of the bill implements two provisions included in the Governor's budget:

1. Eliminate Enhanced Reimbursement for Independent Pharmacies. In the FY 13 midterm budget, the legislature added funding to increase reimbursement for independent pharmacies, which were defined as privately owned community pharmacies with five or fewer stores in Connecticut. The increase in reimbursement is contingent upon federal approval of the Medicaid state plan amendment, which is still pending. Under P.A. 12-1, December special session, the enhanced reimbursement for independent pharmacies was reduced from the average wholesale price (AWP) minus 14% to AWP minus 15%. This bill amends the language further by eliminating the enhanced reimbursement. Reimbursement for independent pharmacies will revert back to earlier levels (AWP minus 16%) and will be consistent with the reimbursement provided for chain pharmacies. Since independent pharmacies often form their own purchasing pools, it is not clear the extent to which the drug costs for independent pharmacies exceed that of chain pharmacies. Savings of \$1.1 million in each year of the biennium is anticipated.
2. Align Pharmacy Dispensing Fee with State Employee Plan. Under P.A. 12-1, December special session, the dispensing fee was reduced from \$2.00 to \$1.70. This bill reduces the dispensing fee further to align with the current levels under the state employee and retiree programs. Savings of \$5.0 million in FY 14 and \$5.2 million in FY 15 are anticipated. (This includes savings of \$2.6 million in each year of the biennium for

annualization of changes under the deficit mitigation plan.)

Sections 18 and 19. Suspend Cost of Living Adjustments for Clients on Public Assistance. Current statute provides recipients of Temporary Family Assistance, State Administered General Assistance and the Aid to the Aged, Blind and Disabled programs a state-funded cost of living adjustment on July 1 of each year. This bill maintains the existing assistance levels by eliminating the projected standards increase of 2.1% in each year of the biennium. It should be noted that Connecticut is one of the few states that allows TFA recipients to keep their earnings up to the federal poverty level. Savings of \$4.6 million in FY 14 and \$9.4 million in FY 15 are anticipated.

Section 19. Apply Annual Social Security Increases to Offset Costs under the Aid to the Aged, Blind and Disabled (AABD) Program. In past years, any cost of living adjustments (COLA) received as part of an AABD client's Social Security benefit were considered an increase in income and applied to the client's cost of care. As a result of a legislative change, effective FY 06, AABD clients now retain their Social Security COLA (by increasing the unearned income disregard) without a concurrent reduction in their state benefit. This bill reinstates the previous policy of applying any federal COLA to offset the cost per case. Savings of approximately \$789,000 in FY 14 and \$1.6 million in FY 15 are anticipated.

Section 20. Expand Eligibility for Low-Income Adults under Medicaid. Pursuant to the Affordable Care Act, beginning January 1, 2014, states can opt to provide Medicaid coverage to all childless adults up to 133% FPL with full federal reimbursement through 2016, after which it will be phased down to 90% by 2020. This bill extends benefits under the Medicaid for Low-Income Adults (HUSKY D) program to eligible individuals with income between 55% and 133% of the federal poverty level. Additional costs of \$51.6 million in FY 14 and \$301.0 million in FY 15 are anticipated.

Sections 21 - 24. Transition Coverage for Certain Adults to the Exchange. The Affordable Care Act creates state-based Health Insurance Exchanges which allow individuals and small businesses to purchase health insurance coverage. Lower income households purchasing health insurance through the Exchange will qualify for significant federal subsidies, lowering the costs associated with obtaining and maintaining comprehensive health insurance coverage beginning January 1, 2014. These federal subsidies will include advanced premium tax credits to reduce the monthly cost of health insurance premiums, as well as additional cost sharing reductions lowering the out-of-pocket, point-of-service costs for obtaining medical care and/or prescription drugs. Due to the availability of insurance coverage through the Health Insurance Exchange, this bill eliminates coverage for ConnPACE clients and certain adults under HUSKY A (with income over 133% of the federal poverty level) effective January 1, 2014. Savings of \$5.8 million in FY 14 and \$59.1 million in FY 15 are anticipated.

Section 25. Clarify Language Regarding the Approval Process of Customized Wheelchairs. As part of deficit mitigation efforts, clinical teams will be sent into facilities to evaluate clients' medical needs and confirm the need for customized

wheelchairs before the purchase of such chairs will be approved. This bill amends the implementing language in P.A. 12-1, December special session, to make clear that while DSS may take a more active utilization management role with regards to requests for customized wheelchairs, there is nothing that prohibits nursing facilities from conducting required assessments. This is a technical revision which will facilitate implementation. There is no fiscal impact associated with this section.

Section 26. Modify Requirements for Nursing Home Advances. Under current statute, DSS can provide an advance to a nursing facility in an amount that does not exceed the amount due to the facility over the most recent two-month period. Statute requires that these advances be made only after consultation with the Secretary of the Office of Policy and Management. Since DSS is required to recover these payments within ninety days, this bill removes the requirement that OPM be consulted before nursing home advances can be approved. There is no fiscal impact associated with this section.

Sections 27 - 31. Reduce Redundancies by Moving the Behavioral Health Partnership Oversight Council under the Council on Medical Assistance Program Oversight. To improve coordination, help avoid duplication of effort among associated committees, and enable the Departments of Social Services, Children and Families, and Mental Health and Addiction Services to consolidate their efforts, staffing and response, this bill combines the Council on Medical Assistance Program Oversight (MAPOC) and the Behavioral Health Partnership Oversight Council into one oversight entity. While it is envisioned that a new behavioral health committee will be established under MAPOC, committees are not delineated in statute, and thus this change will be done administratively. There are no fiscal impacts associated with these sections.

Sections 32 - 52. Delete References to Programs Eliminated Elsewhere. These sections of the bill eliminate references to the Family Support Grant program, the Charter Oak Health Plan, and ConnPACE. See write-ups under sections 21 through 24, 53 and 54.

Note: Two technical corrections are required. Section 35 (lines 1612 - 1628) and section 37 (lines 1666 - 1690) should be deleted as these sections of statute are included in the repealer language (section 54).

Section 53. Repeal Certain Statutory Language. This section of the bill implements the following provisions included in the Governor's budget:

1. **Restructure Behavioral Health Reimbursement** (section 17a-22o). Current statute requires the Departments of Social Services, Children and Families, and Mental Health and Addiction Services to submit all proposals impacting behavioral health rates to the Behavioral Health Partnership Oversight Council for review. If the Council does not recommend approval, it may forward its recommendation to the committees of cognizance, which will then hold a public hearing on the proposed rates. The committees of cognizance are required to make recommendations within ninety days. The statute requires DSS, DCF and DMHAS to make

every effort to incorporate the recommendations of both the Council and the committees of cognizance. Given that the Council is largely comprised of providers who would be impacted by any proposed rate reductions, this bill eliminates this language, thereby allowing DSS to restructure the reimbursement for certain behavioral health services in an effective and efficient manner. DSS is working closely with the Department of Mental Health and Addiction Services to ensure that any adjustments in reimbursement do not negatively impact the state's overall mental health system. The departments will be looking at a number of areas where the state's reimbursement exceeds that of Medicare, which could incentivize providers to bill Medicaid rather than Medicare. In addition, the departments are considering a new rate mechanism for methadone maintenance, with a higher rate for the initial stages of treatment and stabilization and lower rates for long-term maintenance. (Currently providers receive the same weekly rate throughout the entire episode of care.) Savings of \$4.1 million in FY 14 and \$5.1 million in FY 15 are anticipated.

2. Continue to Address Needs for Medicaid Clients with HIV/AIDS through Existing Programs (section 17b-260d). If implemented, the HIV/AIDS waiver will provide home and community-based services beyond those traditionally offered under Medicaid for up to 50 individuals. Services under the waiver would be similar to those available under the department's other waiver programs. Under this bill, the statutory requirement that the department submit a waiver to serve HIV/AIDS clients is eliminated. Individuals who would have otherwise received services under the waiver will continue to be eligible for traditional services under the Medicaid state plan as well as services that they may be eligible for under existing coverage rules. Savings of \$1.3 million in FY 14 and \$2.2 million in FY 15 are anticipated.
3. Eliminate the Family Support Grant Program (section 17b-616). The Governor's budget eliminates funding for the Family Support Grant program, which provides a monthly subsidy to a parent or other family member of a child with a developmental disability. This program is not a core function of the department and is eliminated under this bill. Savings of \$66,855 in each year of the biennium are anticipated.
4. Repealers Related to Other Provisions (sections 17a-22j, 17a-22m and 17a-22n). See write-up for sections 27 - 31 (Reduce Redundancies by Moving the BHP Oversight Council under MAPOC).

Section 54. Repeal Certain Statutory Language. This section of the bill implements the following provisions included in the Governor's budget:

1. Transition Coverage under the Charter Oak Health Plan (section 17b-311). Under the Affordable Care Act, the previous barriers to access to affordable health care are removed with the expansion of health care coverage under Medicaid to individuals up to 133% of the federal poverty level, the establishment of the Exchange, and the federal tax credits that

reduce premium costs, as well as reduced cost sharing for low-income individuals. Since the Charter Oak Health Plan was established to assist those who would not otherwise have access to affordable health insurance, this bill eliminates coverage effective January 1, 2014. Note: This change is reflected in the Governor's budget under current services and, as a result, savings estimates are not available. Program expenditures of \$7.0 million are projected in FY 13.

2. Transition Coverage under ConnPACE (sections 17b-490, 17b-492, 17b-492a and 17b-493 to 17b-498, inclusive). See write-up for sections 21 - 24 (Transition Coverage for Certain Adults to the Exchange).

Note: Two technical corrections are required on line 1986 - "17b-491," should be inserted after "17b-490," and the reference to "17b-492" should be removed.