

DEPARTMENT OF SOCIAL SERVICES

Notice of Intent to Adopt Regulations

In accordance with provisions of subsection (a) of section 4-168 of the 2008 Supplement to the General Statutes, notice is hereby given that the Commissioner of Social Services, under the authority of subsection (g) of section 17b-311 of the Connecticut General Statutes, intends to adopt regulations implementing the Charter Oak Health Plan.

Statement of Purpose: To adopt regulations to administer the Charter Oak Health Plan, which provides access to health insurance coverage for state residents from the ages of 19 through the age of 64 who have been uninsured for at least six months and who are ineligible for other publicly funded health insurance plans.

The program consists of comprehensive health coverage, similar to coverage offered through group health plans, without consideration of pre-existing conditions. Medical services are administered through certain entities, in accordance with subsection (d) of section 17b-311 of the Connecticut General Statutes. Pharmacy services will be administered through the Department of Social Services and behavioral health services will be administered separately, through an administrative services organization.

The proposed regulations contain eligibility and other program requirements for individuals to be enrolled in the program. The Charter Oak Health Plan offers coverage on both a subsidized and non-subsidized basis, depending on income. The proposed regulations set forth the premium, co-payment and deductible requirements and limitations for different income levels. The proposed regulations specify the health benefits covered by the Charter Oak Health Plan, limitations on those benefits and specific services excluded from coverage.

Effective July 1, 2008, the Department of Social Services will implement and operate under the proposed regulations pursuant to subsection (g) of section 17b-311 of the Connecticut General Statutes.

A copy of the complete text of the proposed regulations is available at no cost upon request from the Office of Legal Counsel, Regulations and Administrative Hearings, Department of Social Services, 25 Sigourney Street, Hartford, Connecticut 06106, E-mail: Patricia.Pion@ct.gov.

All interested persons wishing to present their views, questions or concerns regarding the proposed regulations may do so at a public hearing to be held on July

30, 2008 from 10:00 am to 12:00 noon at the Central Office of the Department of Social Services, 25 Sigourney Street, Hartford, CT, Mezzanine Conference Room 1.

All written comments concerning the proposed regulations may be submitted, within 30 days of publication of this notice, to the Department of Social Services, Office of Legal Counsel, Regulations and Administrative Hearings, 25 Sigourney Street, Hartford, CT 06106. Attention: Brenda Parrella

When submitting comments concerning the proposed regulations, please refer to Regulation Control Number 08-08/EA.

R-39 REV. 04/04
IMPORTANT:
Read instructions
on bottom of
Certification Page
before completing
this form. Failure
to comply with
instructions may
cause disapproval
of proposed
Regulations.

STATE OF CONNECTICUT
REGULATION
OF

Name of Agency

Department of Social Services

Subject Matter of Regulation

CHARTER OAK HEALTH PLAN

Section 1. The Regulations of Connecticut State Agencies are amended by adding sections 17b-311-1 to 17b-311-20, inclusive, as follows:

(NEW) Section 17b-311-1. Scope

Sections 17b-311-1 to 17b-311-20, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services eligibility and service benefit requirements for the Charter Oak Health Plan. The Charter Oak Health Plan is an insurance program for adults at least nineteen (19) years of age and under sixty-five (65) years of age who are determined eligible to enroll and receive covered benefits through a managed care entity pursuant to section 17b-311 of the 2008 Supplement to the General Statutes.

(NEW) Sec. 17b-311-2. Definitions

As used in section 17b-311-1 to section 17b-311-20, inclusive, of the Regulations of Connecticut State Agencies:

- (1) "Administrative Services Organization" or "ASO" means an organization contracted with the department to provide administrative and clinically related services, including, but not limited to, claims management, quality management, and benefit information for a specific health or behavioral health benefit;
- (2) "Adult" means an individual who is at least nineteen (19) years of age;
- (3) "Applicant" means an individual who applies for coverage under the Charter Oak Health Plan for:
 - (A) oneself;
 - (B) one's spouse; or
 - (C) oneself and one's spouse;
- (4) "Applied earned income" means that portion of the filing unit's counted earned income that remains after all applicable deductions and disregards are subtracted;
- (5) "Applied income" means that portion of the filing unit's counted income that remains after all applicable deductions and disregards are subtracted and which, when added to any income deemed to the filing unit, is compared to the income guidelines to determine eligibility for the program and the amount of premiums to be paid;
- (6) "Applied unearned income" means that portion of the filing unit's counted unearned income that remains after all applicable disregards and deductions are subtracted;
- (7) "Available income" means all income from which the filing unit is considered to benefit, either through actual receipt of that income or by having the income deemed to exist for the benefit of any particular filing unit member;
- (8) "Behavioral Health Partnership" means the integrated behavioral health service system administered by the Department of Children and Families and the Department of Social Services for HUSKY A and HUSKY B members, children enrolled in Voluntary Services Program operated by the Department of Children and Families and other children, adolescents and families served by the Department of Children and Families, established pursuant to section 17a-22h of the Connecticut General Statutes;

- (9) "Boarder" means an individual who pays an amount of money to someone in exchange for lodging and meals;
- (10) "Business day" means a day that the department is open to the public to conduct the business of the department;
- (11) "Capitation rate" means the individualized amount that the department shall pay to each managed care entity on a monthly basis for each enrollee;
- (12) "Charter Oak Health Plan" or "Charter Oak" means "Charter Oak Health Plan," as defined in section 17b-311 of the 2008 Supplement to the General Statutes;
- (13) "Child" or "Children" means an individual or individuals under nineteen (19) years old;
- (14) "Co-insurance" means the sharing of health care expenses by the member and the department in a specified ratio;
- (15) "Commissioner" means the Commissioner of Social Services;
- (16) "Complaint" means a written or oral communication from a member expressing dissatisfaction with some aspect of a managed care entity's services;
- (17) "Complete application" means an application on which all information requested is provided and that bears the signature of the applicant and the date of signature;
- (18) "Co-payment" means a payment made by or on behalf of an enrollee for a specified service under the Charter Oak Health Plan;
- (19) "Cost-sharing" means arrangements made by or on behalf of the enrollee whereby an enrollee pays a portion of the cost of health services, sharing costs with the state and includes, but is not limited to co-payments, premiums, deductibles, co-insurance and other arrangements described in subsection (b) of section 17b-311 of the 2008 Supplement to the General Statutes;
- (20) "Date of application" means the date on which the department receives a signed application;
- (21) "Deductions" means those amounts that are subtracted as adjustments to counted income and which represent expenses paid by the filing unit;
- (22) "Deemed income" means that portion of income belonging to someone other than the individual requesting coverage or enrollee that is considered available to the filing unit;
- (23) "Deemor" means a person from whom income is considered available to the individual requesting coverage or the filing unit;
- (24) "Denial notice" means a written notice to the applicant or enrollee in which department or the managed care entity informs the applicant or enrollee of its decision to deny eligibility or coverage and of the right to a review of that decision;
- (25) "Department" means the Department of Social Services or its agent;
- (26) "Disregards" means those amounts that are subtracted as standard adjustments to counted income and that do not represent expenses paid by the filing unit;
- (27) "Durable medical equipment" or "DME" means "durable medical equipment" as defined in section 17b-262-673 of the Regulations of Connecticut State Agencies;
- (28) "Earned income" means income that the filing unit receives in exchange for the performance of duties or through self-employment and may be in the form of wages, salary, benefits or proceeds from self-employment;
- (29) "Eligible beneficiary" means an adult who has been determined to meet all of the eligibility requirements for Charter Oak, but who is not yet an enrollee;
- (30) "Eligibility decision" means a decision by the department concerning the denial of eligibility; suspension or termination of enrollment, including disenrollment for failure to pay cost sharing amounts; and includes the department's failure to make a timely determination of eligibility;

- (31) "Emergency care" means the procedures necessary to evaluate or stabilize an emergency medical condition;
- (32) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of a woman or her unborn child, serious impairment of bodily functions or serious dysfunction of any bodily part;
- (33) "Enrollee" or "Member" means an eligible beneficiary who is enrolled with a managed care entity;
- (34) "Essential services" means non-medical services that are provided to disabled individuals over eighteen (18) years of age but under the age of sixty-five (65), such as homemaker or companion services, which are essential to the continued health and well being of the individual;
- (35) "Essential services income" means payments received by an applicant or enrollee in return for that individual providing essential services for the care of a disabled individual at least eighteen (18) years of age but under the age of sixty-five (65), and is considered earned income from self-employment;
- (36) "Filing unit" means the household whose income is used to determine eligibility for Charter Oak;
- (37) "Filing unit member" means any individual who is part of the filing unit;
- (38) "Federal poverty level" means the poverty guidelines updated annually in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 USC 9902(2);
- (39) "Gross earned income" means the total amount of counted earned income before any appropriate deductions or disregards are subtracted. When earnings are from self-employment, the gross amount is the difference between self-employment income and self-employment expenses;
- (40) "Gross unearned income" means the total amount of counted unearned income before any appropriate deductions or disregards are subtracted from it;
- (41) "Group health plan" means "group health plan" as defined in 42 USC 300gg-91;
- (42) "Household" means an adult or couple (married or joined in a civil union) and dependent child of such adult or couple living together;
- (43) "HUSKY Plan, Part A" or "HUSKY A" means assistance provided to children, caretaker relatives and pregnant women pursuant to section 17b-261 or 17b-277 of the Connecticut General Statutes;
- (44) "HUSKY Plan, Part B" or "HUSKY B" means "HUSKY Plan, Part B" as defined in section 17b-290 of the Connecticut General Statutes;
- (45) "Immigrant" means a non-citizen or a North American Indian born in Canada who is lawfully admitted into the United States for the express purpose of maintaining permanent residence;
- (46) "Inaccessible income" means money that a filing unit is owed, but neither receives nor benefits from due to circumstances beyond its control;
- (47) "Income" means income as calculated for purposes of the Medicaid program, pursuant to section 17b-261 of the Connecticut General Statutes;
- (48) "Income-in-kind" means the value of goods, commodities, or services which are provided to the filing unit or to a third party in behalf of the filing unit in lieu of cash.
- (49) "Institution" means an establishment that furnishes food, shelter and some treatment or services to four or more persons unrelated to the proprietor;
- (50) "Intermittent income" means income that is received at recurrent intervals longer than one month;
- (51) "Limited-scope coverage" means health insurance coverage that includes coverage for only a specific type of care, such as optometry, ophthalmology, dental or prescription drugs;

- (52) "Lump sum" means an amount of money that is received by a filing unit or enrollee on a one-time basis and that is not expected to recur;
- (53) "Managed Care Entity" or "MCE" means one of the organizations described in subsection (e) of section 17b-311 of the 2008 Supplement to the General Statutes with which the department has entered into a contract for the purpose of providing services under the Charter Oak Health Plan;
- (54) "Medicaid program" means the program operated by the department pursuant to sections 17b-260, 17b-261 and 17b-277 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, 42 USC 1396 et seq.;
- (55) "Medical and surgical supplies" means "medical and surgical supplies" as defined in section 17b-262-713 of the Regulations of Connecticut State Agencies;
- (56) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;
- (57) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;
- (58) "Non-citizen" means a person who is not a citizen of the United States;
- (59) "Parent" means a natural parent, stepparent, adoptive parent, guardian or custodian of a child;
- (60) "Plan for Achieving Self-Support" or "PASS" is a work incentive program for Supplemental Security Income (SSI) recipients which, in accordance with a plan that has been approved in writing by the Social Security Administration, allows recipients of SSI to set aside income or resources for an educational or training program or to start a business;
- (61) "Premium" means the monthly required payment made by an individual to the department in order to be a member of Charter Oak;
- (62) "Primary care provider" or "PCP" means the licensed health professional with the ability and the responsibility to perform or directly supervise members' primary care services. Such professionals include any of the following:
- (A) physicians whose specialties include: pediatrics, obstetrics/gynecology, internal medicine, family practice and general practice;
 - (B) nurse practitioners;
 - (C) nurse midwives; or
 - (D) physician assistants;
- (63) "Prior authorization" means the process of obtaining prior approval as to the medical necessity or medical appropriateness of a service or plan of treatment;
- (64) "Public institution" means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control;
- (65) "Renewal" means the periodic determination of eligibility of the eligible beneficiary for Charter Oak performed by the department or the single point of entry servicer;
- (66) "Resident" means an individual who lives in Connecticut, and:
- (A) indicates intent to remain in Connecticut permanently or indefinitely; or
 - (B) entered the state with either a job commitment or to seek employment;
- (67) "Roomer" means an individual who pays an amount of money to someone in exchange for lodging, but not meals;

- (68) "Self-employment expenses" are non-personal business expenses directly related to producing goods or services and incurred in a given month;
- (69) "Self-employment income" means the total amount of income derived from a self-employment enterprise before self-employment expenses are deducted;
- (70) "State administered general assistance" or "SAGA" means the cash assistance program funded and administered by the State of Connecticut pursuant to 17b-191 of the Connecticut General Statutes;
- (71) "State administered general assistance medical program" or "SAGA medical" means the medical program funded and administered by the State of Connecticut pursuant to section 17b-192 of the Connecticut General Statutes.
- (72) "State health benefits plan" means a health insurance coverage plan that is offered or organized by the State government on behalf of State employees or other public agency employees within the State, and for which the State or public agency contributes no less than \$10 per month toward a family's medical coverage. The term does not include a plan that provides coverage only for a specific type of care, such as dental or vision care;
- (73) "Student" means an individual who is attending school or a vocational/technical program on either a part-time or full-time basis;
- (74) "Unearned income" means income that does not constitute compensation for work or services performed or business conducted and includes returns from capital investments when the individual is not actively involved in the production of the income;
- (75) "Urgent care" means treatment of illnesses or injuries of a less serious nature than those constituting an emergency and
- (A) are required in order to prevent a serious deterioration in the enrollee's health; and
 - (B) cannot be delayed, without imposing undue risk on the enrollee's well being, until the enrollee is able to secure services from his or her regular physician or physicians;
- (76) "Workforce Investment Act" payments or "WIA" means payments made pursuant to 29 USC 2801 et seq.

(NEW) Sec. 17b-311-3. Financial eligibility

An adult who is ineligible for any other publicly funded health insurance program, due to excessive income or other eligibility criteria, may have his or her filing unit's income evaluated to determine whether, and if so, to what degree, the adult's Charter Oak benefits shall be subsidized by the department.

(a) Income Bands

Adults who meet all financial and other eligibility requirements with a filing unit income that does not exceed three hundred percent (300%) of the federal poverty level are eligible for subsidized benefits under Charter Oak. Adults who meet all financial and other eligibility requirements and reside in a household with a filing unit income over three hundred percent (300%) of the federal poverty level are eligible for non-subsidized benefits under the Charter Oak Health Plan.

Adults found eligible for Charter Oak shall be placed in income bands as follows:

- (1) Band 1 – applied income that does not exceed one hundred fifty percent (150%) of the federal poverty level;
- (2) Band 2 – applied income that exceeds one hundred fifty percent (150%) of the federal poverty level, but does not exceed one hundred eighty-five percent (185%) of the federal poverty level;
- (3) Band 3 – applied income that exceeds one hundred eighty-five percent (185%) of the federal poverty level, but does not exceed two hundred thirty-five percent (235%) of the federal poverty level;

- (4) Band 4 – applied income that exceeds two hundred thirty-five percent (235%) of the federal poverty level, but does not exceed three hundred percent (300%) of the federal poverty level; and
- (5) Band 5 – applied income that exceeds three hundred percent (300%) of the federal poverty level.

(b) Counted income

Counted income is all income that is not specifically excluded under subsection (c) of this section and that is available income to any member of the filing unit. Counted income is the amount that is used in determining the amount of applied income.

(c) Excluded income

The types of income listed in this subsection shall not be counted in determining eligibility for Charter Oak.

- (1) Payments made to volunteers, including payments made for supportive services or reimbursement of out-of-pocket expenses, are excluded when made to individual volunteers serving as foster grandparents, senior health aids or senior companions and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and any other programs pursuant to Title II and Title III, section 418 of Public Law 93-113;
- (2) Payments made to children or on their behalf, including but not limited to:
 - (A) adoption assistance payments from federal, state and local funds for an adopted child who is part of the filing unit whether or not that child is applying for HUSKY;
 - (B) foster care payments received from federal, state or local funds for the care of foster children placed in the care of the filing unit; and
 - (C) supplemental food assistance when received under the Child Nutrition Act of 1966, as amended from time to time, and the Special Food Service Program for Children under the National School Lunch Act, as amended from time to time, Public Law 92-433 and Public Law 93-150.
- (3) Payments made to Indian tribe members, including:
 - (A) payments from Indian judgment funds, including any interest paid, distributed to, or held in trust for members of various Indian tribes pursuant to Public Law 98-64; and
 - (B) receipts distributed to members of certain Indian tribes that are referred to in section 5 of Public Law 94-114 that became effective October 17, 1975.
- (4) Miscellaneous payments, including:
 - (A) payments made under the Experimental Housing Allowance program under annual contributions contracts entered into prior to January 1, 1975, under section 23 of the United States Housing Act of 1937, as amended from time to time;
 - (B) the value of food stamp allotments made under the Food Stamp program;
 - (C) cash contributions from agencies and organizations for goods and services not included in the department's standards of need;
 - (D) gifts received too irregularly or infrequently to be counted, but not more than \$30 per calendar quarter;
 - (E) the value of goods and services given as in-kind income, except when provided by State Administered General Assistance (SAGA);

- (F) settlement payments received by filing units that are members of the nationwide class of present and former tenants covered by the settlement of the Underwood v. Harris court case;
- (G) payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;
- (H) payments made under means-tested energy assistance programs;
- (I) reimbursements for expenditures that do not represent benefit or gain to the recipients;
- (J) money received on behalf of a person who is not a member of the filing unit and used for his or her care and support;
- (K) payments made for the expenses of day care and essential services provided to a member of the filing unit unless the provider is another filing unit member;
- (L) support payments only when collectable by the department IV-D Support Program pursuant to an assignment of support rights and which are not passed through to the filing unit;
- (M) payments made to volunteers under Title I, Vista Volunteers, section 404 (g) of Public Law 93-113, except when the Director of Action determines that the payment is equal to, or greater than, the minimum wage in effect under the Fair Labor Standards Act of 1938 or the state minimum wage, whichever is greater;
- (N) disaster assistance paid under the Disaster Relief Act of 1974, as amended from time to time, including, but not limited to, the Individual and Family Grant (IFG) program, and comparable disaster assistance provided by states, local governments and private organizations and any interest earned on funds from this source;
- (O) payments made by the Department of Labor to meet the cost of pursuing employment;
- (P) utility subsidies;
- (Q) security deposits returned to the filing unit;
- (R) rent money returned to a filing unit by a court;
- (S) that portion of military pay that is withheld as funding for the G.I. Bill under Public Laws 94-502 and 99-576;
- (T) earned income tax credit payments received as advance payments or as a single non-recurring payment;
- (U) Agent Orange payments made pursuant to Public Law 101-201 and section 10405 of Public Law 101-239;
- (V) Japanese Restitution payments and payments to residents of the Aleut and Pribilof Islands made pursuant to Public Law 100-383;
- (W) Radiation Exposure Compensation payments made pursuant to section 6 (h)(2) of Public Law 101-246;
- (X) up to \$2,000 in total cash payments per year per individual made pursuant to section 15 of the Alaska Native Claims Settlement Act, Public Law 100-241;
- (Y) payments made to victims of Nazi persecution pursuant to Public Law 103-286;
- (Z) payments made to certain hemophilia patients who contracted HIV from blood transfusions:
 - (i) Payments made under the settlement of Factor VIII or IX Concentrate Blood Products Litigation MDL 986 (No. 93-C- 7542, Northern District of Illinois) pursuant to section 4735 of the Balanced Budget Act of 1997;

(ii) payments received under the Ricky Ray Hemophilia Relief Fund Act of 1998 (the Ricky Ray Act), Public Law 105-369.

(AA) payments received as rebates from support collected under the Title IV-D Support Program as provided by the Deficit Reduction Act (DEFRA) of 1984;

(BB) income that is earned by a student who is a child; or

(CC) payments made under the settlement to the Susan Walker v. Bayer Corporation, et al. court case, (No. 93-C-5024, Northern District of Illinois) are excluded pursuant to section 4735 of the Balanced Budget Act of 1997.

(d) Accessible income

The department shall consider all counted income to be accessible to the applicant, unless otherwise indicated. If the counted income is accessible at any time in the month, then it is considered accessible throughout the entire month.

(e) Deemed income – general principles

The general principles listed in this subsection shall be used with respect to deeming income to the filing unit.

(1) In calculating the amount of deemed income, the income of the deemor shall be counted in full, except for those reductions specifically provided for in this subsection.

(2) Income exclusions applicable to the filing unit as set forth in subsection (b) of section 17b-311-3 of the Regulations of Connecticut State Agencies shall be applied to the income of the deemor.

(3) None of the deemor's income is deemed if he or she:

(A) is a recipient of Supplemental Security Income (SSI) or payments from the State Supplement (AABD) program;

(B) receives federal, state or local foster care maintenance payments or adoption assistance payments; or

(C) is a recipient of financial assistance from the temporary financial assistance (TFA) program or SAGA .

(f) Conversion to monthly amounts

(1) If income is received on a monthly basis, a representative monthly amount shall be used as the estimate of income.

(2) If income is received on other than a monthly basis, the estimate of income shall be calculated by multiplying 4.3 by a representative weekly amount that is determined as follows:

(A) if income is the same each week, the regular weekly income shall be the representative weekly amount;

(B) if income varies from week to week, a representative period of at least four consecutive weeks shall be averaged to determine the representative weekly amount;

(C) if there has been a recent change or if there is an anticipated future change, the amount expected to represent future income shall be the representative weekly amount; or

(D) if income is received on other than a weekly or monthly basis, the income shall be converted to a representative weekly amount by dividing the income by the number of weeks covered.

- (3) When income is received less frequently than monthly, the department shall prorate payments over a period of time in the following situations:
- (A) when the income was earned over a past period of time, the payment shall be averaged retroactively over the number of months in which it was earned;
 - (B) when the income is paid subject to an employment agreement that provides for periodic advances to cover future needs, the payment shall be averaged by the number of months for which it is intended; or
 - (C) when the income consists of unearned income paid on an installment basis, either resulting from the nature of the source or pursuant to an agreement between the payer and payee, the payment shall be averaged over the number of future months the amount is intended to cover.
- (4) When income is received less frequently than monthly, the amount of the payment shall be counted as income in the month of receipt when there is no period of time associated with the payment. Any portion of the payment that is retained by the family economic filing unit in the following month shall not be counted as income in that month.
- (5) The amounts of income from a particular source that are designated for future months shall continue to be counted as income for those months.
- (6) For self-employment the monthly income shall be determined based on an evaluation of income over at least the last twelve (12) months prior to the date of application.
- (g) Disregard from child support payments
- The total amount of child support payments made by a non-custodial parent towards the current month's need, whether paid through the department, Bureau of Child Support Enforcement or directly to the filing unit by the absent parent, shall be subject to a disregard of \$100 before it is counted. In addition:
- (1) voluntary payments not made pursuant to a formal agreement shall also be subject to the disregard; and
 - (2) payments or any portion of payments that are made toward past-due support shall not be subject to the disregard;
- (h) Deductions – self-employment expenses
- (1) Expenses of self-employment shall be deducted from each filing unit member's total gross monthly income earned through self-employment.
 - (2) The following may be considered business expenses and may be included as allowable deductions:
 - (A) the actual amounts of overhead expenses including, but not limited to, costs, such as rent, fuel, utilities and equipment, cost of stock or raw materials purchased and payments to or on behalf of employees, but not including depreciation; and
 - (B) if the self-employment income is derived from providing room or board or both, the department's standard allowances for expenses associated with providing room or board, or both, as provided for in subdivision 18 of subsection (m) of this section, or the actual expenses if greater.
 - (3) Self-employment expenses shall be converted to a monthly amount in the same manner as self-employment income is converted to a monthly amount.
- (i) Deductions – personal employment expenses
- There shall be a deduction of \$90 per month from gross earned income for each employed person for personal employment expenses.
- (j) Deductions - day care expenses

- (1) A deduction for day care expenses shall be subtracted from a filing unit member's earned income when he or she incurs expenses for the care of a child or an incapacitated adult, provided that the following conditions are met:
 - (A) the child or adult is a member of the filing unit;
 - (B) the day care cost is not reimbursed by the department or by a third party;
 - (C) the day care provider is not the parent or legal guardian of the person receiving care, or a member of the filing unit; and
 - (D) day care is required in order for a filing unit member to maintain employment.
 - (2) The deduction for day care expenses shall not be subtracted from a filing unit member's earned income if the day care provider is the filing unit member's natural child, adopted child or stepchild who is under twenty-one (21) years of age, unless the day care provider:
 - (A) does not live with the filing unit;
 - (B) is an emancipated minor under state law;
 - (C) was not claimed as a dependent on the filing unit member's most recent federal tax return; and
 - (D) has a bona fide employer or employee relationship with the filing unit member.
 - (3) The amount of the deduction for a given month shall be based on charges for day care services performed in that particular month.
 - (4) The day care deduction shall be equal to the actual cost of the day care, up to the following maximum amounts:
 - (A) \$200 per month for each child under two (2) years of age; and
 - (B) \$175 for an adult, or for each child age two (2) or older.
 - (5) All other HUSKY A and HUSKY B requirements regarding day care expense deductions, as applicable, shall apply to Charter Oak.
- (l) Deductions – Plan for Achieving Self-Support (PASS)
- (1) Criteria for allowing the deduction

Earned and unearned income shall be reduced by the actual PASS deduction made by the Social Security Administration in computing the individual's SSI benefit when the PASS is:

 - (A) designed especially for the individual;
 - (B) in writing; and
 - (C) approved by the Social Security Administration.
 - (2) Duration of the deduction

The deduction shall be allowed for the same period of time that the Social Security Administration uses the PASS deduction in calculating the individual's SSI benefit.
 - (3) Amount of the deduction

The amount of the deduction shall be equal to the actual PASS deduction made by the Social Security Administration when computing the individual's SSI benefit.
- (m) Treatment of specific types of income
- (1) Alimony

Alimony that is received directly by a member of the filing unit shall be counted in total as unearned income to the extent payments are not collectable by the department's IV-D Support Program.

(2) Annuity and pension payments

Payments received by the filing unit from annuity plans and pensions shall be considered unearned income.

(3) Assistance payments from other states

Public assistance payments from other states received by the filing unit during the month for which eligibility in Connecticut is being determined shall be counted as unearned income available to the filing unit in that month.

(4) Benefits (Social Security Administration, SSI, Veterans Administration)

Income from Social Security, SSI and veterans' benefits shall be treated as unearned income available to the filing unit.

(5) Cash contributions

(A) Cash contributions made to the filing unit from non-legally liable relatives, friends or organizations shall be treated as unearned income and counted in full if the amount is regularly and predictably contributed, and exceeds \$30 per calendar quarter.

(B) Money borrowed by the filing unit from any source subject to a written agreement to repay shall be regarded as a loan rather than as a contribution.

(6) Child support payments

(A) The total amount of child support payments made by a non-custodial parent in a given month toward the current month's need, whether paid through the department, the Bureau of Child Support Enforcement or directly to the filing unit by the non-custodial parent, and whether made voluntarily or pursuant to a formal agreement, shall be subject to a \$100 child support disregard.

(B) Child support payments made toward a past-due support obligation shall not be subject to the disregard.

(C) The total amount of existing child support payments made toward the current month's need, after the child support disregard is subtracted, shall be added to all other applied income when determining eligibility, regardless of whether it is received by the filing unit or collected by the department.

(D) All other HUSKY A and HUSKY B requirements related to the child support disregard shall apply to Charter Oak.

(7) Dividends, interest, trusts and royalties

Income from dividends, interest, trusts, and royalties shall be counted as unearned income when it is actually paid to a member of the filing unit. Income from these sources that is not paid to the filing unit and that accumulates to the source of the income shall not be counted as income.

(8) Earned income received by children

Earned income of a dependent child who is a student, either part time or full-time, shall be excluded.

(A) For applicants, non-WIA earnings are excluded for six (6) months per calendar year, regardless of the child's student status; and

(B) For enrollees, non-WIA earnings are excluded for six (6) months per calendar year if the dependent child is a full-time student and are excluded for an indefinite period of time if the dependent child is a full-time student who is not employed full time.

(9) Essential services income

The total monthly amount received for essential services shall be reduced by self-employment expenses to calculate the amount of applied earned income.

(10) Gratuities

- (A) When employment involves the receipt of gratuities in addition to wages, gratuity amounts that can be separately identified by the filing unit shall be added to wages to determine the total gross amount of earned income.
- (B) An amount of fifteen (15) percent of the monthly gross wages shall be used as the gratuity amount when the filing unit cannot identify the amount of gratuities received.
- (C) Special allowances added to basic wages by the employer for such items as cleaning of uniforms and for meals shall be counted as earned income. No special work expenses are added to the personal work expense deduction of \$90.

(11) Home equity conversion plans

Money received by the filing unit that is the result of a home equity conversion plan that requires a repayment agreement is treated as a loan and is excluded. Money received through a home equity conversion plan that does not include a repayment agreement is counted as unearned income.

(12) Income-in-kind

Income-in-kind shall be excluded from consideration as income in determining eligibility, except when provided through SAGA. When an item of need, i.e. clothing, shelter, transportation, etc., is provided to the filing unit in return for the performance of services by the filing unit, the value of the item shall be treated as earned income and shall not be considered income-in-kind.

(13) Loans

Money that is received by the filing unit from a person or an organization subject to a written repayment agreement shall be excluded as income. If no written repayment agreement exists, the money shall be treated as income in the month of receipt.

(14) Lump sums

Lump sums shall be regarded as assets and shall not be counted as part of the filing unit's income.

(15) Rental income

- (A) Income received by the filing unit from renting property to someone else shall be treated as unearned self-employment income, unless the income is derived from a business enterprise.
- (B) Rental property income derived from a business enterprise shall be treated as self-employed earned income and shall be reduced by the disregard in subsection (j) of this section.

(16) Roomer and boarder income

- (A) Payments received from roomers or from boarders, or from both, shall be treated as earned income acquired through self-employment.
- (B) The total monthly amount shall be reduced by the designated monthly allowances for expenses associated with providing room or board, or both, or the actual expenses if greater, and the appropriate deduction for personal employment expenses.

- (C) The designated monthly allowances for expenses associated with providing room or board, or both, shall be the following amounts, or the actual expenses if greater:
 - (i) \$40 for one person who is a roomer and \$20 for each additional roomer;
 - (ii) \$115 for one person who is a boarder and \$60 for each additional boarder.

(17) SAGA

SAGA cash payments shall be counted in their entirety as unearned income.

(18) Sick pay benefits

- (A) Sick pay benefits received from an employer shall be treated as earned income subject to appropriate deductions.
- (B) Income from sick pay benefits paid through private insurance shall be treated as unearned income subject to appropriate deductions.

(19) Student income

- (A) Educational funding, including, but not limited to, grants, scholarships, educational loans or work study earnings paid to a student from any federal, state or private source, shall be excluded.
- (B) Unearned income that does not constitute educational funding shall be counted subject to appropriate disregards and exclusions.
- (C) Income for educational purposes from any federal, state or private-source college work study programs shall be totally excluded from consideration.
- (D) WIA payments made to students shall be excluded as income.

(20) Vacation and severance pay

Vacation and severance pay shall be treated as earned income in the month of receipt and subject to appropriate deductions and disregards.

(21) Workforce Investment Act

WIA payments made to adults who are not students shall be counted as earned income as long as they do not constitute a reimbursement for expenses incurred by the adult. WIA income received by a child who is a student shall be excluded.

(22) All other requirements regarding the treatment of specific types of income in HUSKY A and HUSKY B shall apply to the treatment of such income in Charter Oak.

(n) Applied income

(1) The department shall calculate the filing unit's applied earned income in the following manner:

- (A) the filing unit's total monthly earnings shall be adjusted to a monthly gross earned income amount by subtracting any monthly self-employment expenses, if applicable; and
- (B) the filing unit's monthly-applied earned income shall be calculated by subtracting the following amounts from the monthly gross earnings in the following order:
 - (i) a deduction for personal work expenses;
 - (ii) a deduction for day care; and
 - (iii) a deduction for the actual amount of earned income allowed by the Social Security Administration as a deduction in calculating the filing unit member's SSI benefits. This deduction shall apply to filing unit

members who receive SSI for the blind or disabled and have an approved PASS.

- (C) The department shall calculate the filing unit's monthly applied unearned income by subtracting from the filing unit's total gross unearned income the appropriate disregard from child support payments received by the filing unit and the actual PASS deduction allowed by the Social Security Administration in calculating an individual's SSI.
- (2) All income deemed to the filing unit members shall be applied income.
- (3) The department shall calculate the total monthly amount of applied income by adding together the monthly-applied earned income, monthly-applied unearned income and the amount of monthly-deemed income.
- (4) The department shall use the total monthly applied income to determine the appropriate income band for Charter Oak.

(NEW) Sec. 17b-311-4. Non-financial eligibility requirements

(a) Age

The filing unit member shall be at least nineteen (19) years of age and under sixty-five (65) years of age.

(b) Residency

- (1) The filing unit member shall be a resident of Connecticut.
- (2) A filing unit member's temporary absence from Connecticut shall not constitute abandonment of residency or disrupt eligibility if it is expected that he or she will return to Connecticut once the purpose of the absence has been accomplished.

(c) Social security number

An individual who is requesting coverage is not required to provide a social security number in order to obtain benefits under Charter Oak, although he or she may provide his or her social security number voluntarily.

(d) Living arrangement

An incarcerated individual shall not be eligible for Charter Oak.

(e) Insurance coverage

- (1) An individual on whose behalf coverage is requested, who, at the time of application, is enrolled in either a group health plan or health insurance coverage shall be ineligible for Charter Oak. Such individual is not considered covered under a group health plan or health insurance coverage if he or she does not have reasonable geographic access to care under the plan. If a group health plan or health insurance coverage provides only limited-scope coverage for a service covered under Charter Oak, such individual may be eligible for Charter Oak, but not an enrollee until such time as the limited-scope coverage is discontinued. A member shall lose eligibility for Charter Oak the first day of the month he or she becomes enrolled in any group health plan or health insurance coverage.
- (2) An individual on whose behalf coverage is requested who, at the time of application, is eligible to be enrolled in another publicly financed health insurance plan, shall be ineligible for Charter Oak.
- (3) An individual on whose behalf coverage is requested who, at the time of application, is eligible to be enrolled in a federal, state or municipal health benefits plan, on the basis of a filing unit member's or other family member's employment with a federal, state or municipal agency, shall be ineligible for Charter Oak.
- (4) An individual on whose behalf coverage is requested, who is or was enrolled in either a group health plan or private health insurance coverage, except for a plan that provided only limited-scope coverage, shall be ineligible for Charter Oak for six (6) months from

the date the coverage ended, unless the coverage ended for reasons unrelated to the availability of the Charter Oak, including, but not limited to:

- (A) loss of employment due to factors other than voluntary termination;
 - (B) loss of coverage due to divorce, dissolution of a civil union or death of spouse or parent;
 - (C) change to a new employer that does not offer any health insurance coverage for employees or provide an option for dependent coverage;
 - (D) loss of coverage due to lack of eligibility to continue on a parent's health insurance policy because of age or other factor;
 - (E) discontinuance of health benefits to all employees of the requesting individual's employer, as long as the discontinuance is not related to the availability of Charter Oak, as established by the submission of an affidavit by such employer;
 - (F) expiration of the coverage periods established by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, Public Law 99-272;
 - (G) termination of health benefits due to a long-term disability;
 - (H) termination of coverage due to an extreme economic hardship, as determined by the department, including, but not limited to, excessive combined premiums or out-of-pocket costs due to a household member's illness not being covered by insurance;
 - (I) exhausted lifetime medical benefits or benefit category available to an employee and dependents under an employer's health care plan; or
 - (J) any other reason deemed by the department to be unrelated solely to the availability of Charter Oak.
- (5) An individual who was disenrolled or discontinued from Medicaid, SAGA medical, HUSKY A or HUSKY B for any reason, including age or increase in earnings, shall not be precluded from eligibility for Charter Oak if otherwise eligible.

(g) Citizenship

An adult must be a citizen of the United States, or an eligible non-citizen, to be eligible for Charter Oak.

(h) Eligible non-citizens arriving in the United States prior to August 22, 1996:

An eligible non-citizen who arrived in the United States prior to August 22, 1996 but does not apply for benefits until on or after that date, and:

- (1) is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act; or
- (2) is granted asylum under section 208 of the Immigration and Nationality Act; or
- (3) whose deportation is being withheld under section 243(h) of the Immigration and Nationality Act as in effect immediately before the effective date of section 307 of division C of Public Law 104-208, or section 241(b)(3) of the Immigration and Nationality Act as amended by section 305(a) of division C of Public Law 104-208; or
- (4) is lawfully admitted to the United States for permanent residence under the Immigration and Nationality Act; or
- (5) is paroled into the United States under section 212(d) of the Immigration and Nationality Act for a period of at least one year; or
- (6) is granted conditional entry pursuant to section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980; or
- (7) is lawfully residing in the state and is:

- (A) a veteran, as defined in section 101, 1101 or 1301, or as described in 38 USC 107, with a discharge characterized as an honorable discharge and not on account of alienage and who fulfills the minimum active duty service requirements of 38 USC 5303 A(d); or
 - (B) on active duty, other than active duty for training, in the armed forces of the United States; or
 - (C) the spouse or civil union partner of an individual described in subdivision (A) or (B) of this subparagraph or the unmarried surviving spouse of a deceased individual described in (A) or (B) if the marriage fulfills the requirements of 38 USC 1304; or
- (8) is granted status as a Cuban or Haitian entrant under section 501 (e) of the Refugee Education Assistance Act of 1980; or
 - (9) is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 as contained in section 101 (e) of Public Law 100-202 and amended by the 9th proviso under Migration and Refugee Assistance in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, Public Law 100-461 as amended; or
 - (10) is an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act apply; or
 - (11) is a member of an Indian tribe under section 4 (e) of the Indian Self-Determination and Education Assistance Act; or
 - (12) is receiving SSI; or
 - (13) has been battered or subjected to extreme cruelty in the United States by a spouse, civil union partner, or parent, or by a member of the spouse, or parent's family living with the non-citizen, and the spouse or parent allowed such battery or cruelty to occur, but only if the department determines that the battery or cruelty has contributed to the need for medical assistance and the individual responsible for such battery or cruelty is not presently residing with the person subjected to such battery or cruelty, and the non-citizen has been approved or has an application pending with the USCIS under which he or she appears to qualify for one of the following:
 - (A) status as a spouse or child of a United States citizen pursuant to clause (i), (ii), (iii), or (iv) of section 204(a)(1)(A) of the Immigration and Nationality Act; or
 - (B) classification pursuant to clause (i), (ii) or (iii) of section 204(a)(1)(B) of the Immigration and Nationality Act; or
 - (C) suspension of deportation and adjustment of status pursuant to section 244(a)(3) of the Immigration and Nationality Act; or
 - (D) status of a spouse or child of a U.S. citizen pursuant to clause (i) of section 204(a)(1)(A) of such act, or classification pursuant to clause (i) of section 204(a)(1)(B) of such act; and
 - (E) the individual responsible for such battery or cruelty is not presently residing with the person subjected to such batter or cruelty.
 - (14) is a non-citizen whose child has been battered or subjected to extreme cruelty in the United States by a spouse, civil union partner, or parent of the non-citizen without the active participation of the non-citizen in the battery or cruelty, or by a member of the spouse's or parent's family living with the non-citizen and the spouse or parent allowed such battery or cruelty to occur, but only if the criteria in subparagraph (M) of this subdivision are met; or
 - (15) is a non-citizen child living with a parent who has been battered or subjected to extreme cruelty in the United States by that parent's spouse, or by a member of the spouse's family living with the parent and the spouse allowed such battery or cruelty to occur, but only if the criteria in subparagraph (M) of this subdivision are met; or

- (16) is lawfully residing in the United States and who was a member of a Hmong or Highland Laotian Tribe at the time that tribe rendered assistance to United States personnel during the Viet Nam era. The individual's spouse or surviving spouse is also eligible.

(i) Eligible non-citizens arriving in the United States on or after August 22, 1996:

An eligible non-citizen adult is an adult who arrived in the United States on or after August 22, 1996 and meets any of the conditions as described below:

- (1) is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act; or
- (2) is granted asylum under section 208 of the Immigration and Nationality Act; or
- (3) whose deportation is being withheld under section 243(h) of the Immigration and Nationality Act as in effect immediately before the effective date of section 307 of division C of Public Law 104-208, or section 241(b)(3) of the Immigration and Nationality Act as amended by section 305 (a) of division C of Public Law 104-208; or
- (4) is lawfully residing in the state, and is:
 - (A) a veteran as defined in section 101, 1101 or 1301, or as described in 38 USC 107, with a discharge characterized as an honorable discharge and not on account of alienage, and who fulfills the minimum active duty service requirements of 38 USC 5303A(d); or
 - (B) on active duty, other than active duty for training, in the armed forces of the United States; or
 - (C) the spouse or civil union partner of an individual as described in (A) or (B) of this subparagraph or the unremarried surviving spouse of a deceased individual described in subparagraph (A) or (B) of the marriage fulfills the requirements of 38 USC 1304; or
- (5) is granted status as a Cuban or Haitian entrant under section 501 (e) of the Refugee Education Assistance Act of 1980; or
- (6) is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 as contained in section 101 (e) of Public Law 100-202 and amended by the 9th proviso under Migration and Refugee Assistance in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, Public Law 100-461, as amended; or
- (7) is an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act apply; or
- (8) is a member of an Indian tribe under section 4 (e) of the Indian Self-Determination and Education Assistance Act; or
- (9) is receiving SSI; or
- (10) is lawfully residing in the United States and who was a member of a Hmong or Highland Laotian Tribe at the time that tribe rendered assistance to United States personnel during the Viet Nam era. The individual's spouse or surviving spouse or surviving civil union partner are eligible also; or
- (11) is lawfully residing in the United States and:
 - (A) is lawfully admitted to the United States for permanent residence under the Immigration and Nationality Act; or
 - (B) is paroled into the United States under section 212 (d) of the Immigration and Nationality Act for a period of at least one year; or
 - (C) is granted conditional entry pursuant to section 203 (a) (7) of the Immigration and Nationality Act as in effect prior to April 1, 1980; or

- (12) has been lawfully residing in the United States and has been battered or subjected to extreme cruelty in the United States by a spouse, parent, or by a member of the spouse or parent's family living with the non-citizen, and the spouse or parent allowed such battery or cruelty to occur, but only if the department determines that the battery or cruelty has contributed to the need for medical assistance and the individual responsible for such battery or cruelty is not presently residing with the person subjected to such battery or cruelty and the non-citizen has been approved or has an application pending with the USCIS under which he or she appears to qualify for at least one of the following:
- (A) status as a spouse of a United States citizen pursuant to clause (i), (ii), (iii), or (iv) of section 204(a)(1)(A) of the Immigration and Nationality Act; or
 - (B) classification pursuant to clause (i), (ii), or (iii) of section 204(a)(1)(B) of the Immigration and Nationality Act; or
 - (C) suspension of deportation and adjustment of status pursuant to section 244(a)(3) of the Immigration and Nationality Act; or
 - (D) status of a spouse of a U.S. citizen pursuant to clause (i) of section 204(a)(1)(A) of such act, or classification pursuant to clause (i) of section 204(a)(1)(B) of such act; and
 - (E) the individual responsible for such battery or cruelty is not presently residing with the person subjected to such batter or cruelty; or
- (13) is lawfully residing in the United States and:
- is a non-citizen whose child has been battered or subjected to extreme cruelty in the United States by a spouse, or parent of the non-citizen without the active participation of the non-citizen in the battery or cruelty, or by a member of the spouse's or parent's family living with the non-citizen and the spouse or parent allowed such battery or cruelty to occur, but only if the criteria in subparagraph (12) of this subdivision are met;

(j) Cooperation

- (1) As a condition of eligibility, applicants and enrollees shall cooperate in all respects regarding the establishment of whether they meet, or continue to meet the eligibility requirements for Charter Oak, including, but not limited to:
- (A) fully completing and signing the application and renewal forms, as well as providing and verifying information as required by the department; and
 - (B) reporting all changes that may occur in respect to any information that was previously reported, on either the application or renewal forms, not later than ten working days after the date of the change;

(NEW) Sec. 17b-311-5. Eligibility determination process

(a) Application processing

- (1) Individuals who wish to apply for Charter Oak benefits shall complete a written application and submit it to the department.
- (2) The applicant shall be responsible for providing all necessary information and documentation required to determine eligibility for Charter Oak, and for returning a signed application to the department.
- (3) The department shall consider the date of application to be the date the signed application is received by the department.
- (4) The department shall process all applications within thirty (30) business day of receipt. The department shall determine eligibility for Charter Oak by the seventh calendar day following the date all required information is received. If an application remains incomplete after thirty (30) days from the date of receipt, the department will notify the applicant that the application has been denied for failure to submit all required information.

- (5) The department will consider eligibility for other publicly funded healthcare programs administered by the department and based on the information provided on the application for Charter Oak.
 - (6) The department shall provide notice to the applicant, in writing, regarding the application and eligibility requirements; the time frame for determining eligibility; and the right to review eligibility determinations. If eligibility is approved, the notice shall include information about the enrollee's rights and responsibilities under the program, including the opportunity for an administrative review concerning the eligibility determination.
- (b) Eligibility renewal
- (1) The department shall redetermine eligibility for Charter Oak at least once every twelve (12) months.
 - (2) The department shall send a renewal form to obtain information needed to determine whether the enrollee remains eligible for Charter Oak.
 - (3) The member shall be responsible for providing all the information and verification requested on the form, signing the form and returning it to the department not later than the first day of the last month of the eligibility period.
 - (4) The department shall redetermine eligibility for Charter Oak on the basis of the information provided on the form and render a decision not later than the last day of the last month of the current eligibility period.
 - (5) If the department has not received information and verification needed to complete the renewal, as provided in subdivision (4) of this subsection, eligibility shall end as of the last day of the eligibility period. Any subsequent eligibility shall be established only through the processing of a new application in accordance with subsection (a) of this section.
 - (6) The department shall send the member a notice of its decision concerning eligibility renewal and information about the availability of the administrative review process.
- (c) Eligibility period
- An adult who has been determined to be eligible for and enrolled in Charter Oak shall remain eligible and enrolled in Charter Oak unless the adult:
- (1) reaches sixty-five (65) years of age;
 - (2) dies;
 - (3) enrolls in any health insurance plan, including limited-scope coverage for any good or service covered under Charter Oak;
 - (4) ceases to be an eligible non-citizen;
 - (5) becomes incarcerated;
 - (6) becomes eligible for another publicly funded health insurance plan;
 - (7) becomes eligible for a state, federal, or municipal health benefits plan on the basis of a filing unit member's or other family member's employment;
 - (8) ceases to be a Connecticut resident; or
 - (9) failed to complete a renewal application or provide information requested by the department to determine eligibility.
- (d) Processing interim changes
- (1) The enrollee shall be required to report any change in circumstances that may affect eligibility not later than ten (10) days after the change.

- (2) Changes may be reported by telephone or in writing. The department shall determine the impact of reported changes on the member's eligibility and shall notify the member of its intended action not later than ten (10) days after the change is reported.
 - (3) Changes listed in subsection (c) of this section shall have an immediate impact on eligibility and shall be implemented as of the first of the month following the month in which they occur.
- (e) Verification process
- (1) The department shall consider a statement made by the applicant or the enrollee to be verified when the available evidence indicates that it is more likely than not to be true.
 - (2) The department shall require verification of information pertaining to the non-citizenship status of applicants and enrollees seeking redetermination.
 - (3) The department shall require verification of information whenever necessary to corroborate an applicant's or enrollee's statements.
 - (4) If the eligibility of an individual requesting coverage depends directly upon a factor or circumstance for which verification is required by the department, his or her failure to provide verification shall result in the denial of eligibility.
 - (5) The applicant or enrollee shall bear the responsibility for providing evidence to corroborate statements and may submit any evidence to support such statements.
 - (6) The department may accept affidavits when documentary evidence is required and the applicant or enrollee cannot provide it, despite good faith efforts, or when documentary evidence does not exist to demonstrate the nonexistence of an eligibility factor.
 - (7) The department shall consider all evidence submitted by the applicant or enrollee or from any other sources when making its eligibility decisions.

(NEW) Sec. 17b-311-6. Administrative review processes

- (a) There shall be an administrative review process regarding Charter Oak eligibility decisions as described in this subsection.
 - (1) The department shall conduct an initial level one administrative review of its eligibility decisions when the request for review is received not later than ten (10) calendar days from the date on the eligibility decision notice sent to the filing unit.
 - (2) The department shall attempt to resolve the filing unit's concern, and shall notify the filing unit of its level one administrative review decision in writing not later than ten (10) calendar days after receipt of a request for review.
 - (3) If the filing unit's concerns cannot be resolved to the his or her satisfaction through this initial level one administrative review, the department shall assign an administrative reviewer to conduct a level two administrative review, if requested in writing by the filing unit, not later than ten (10) calendar days following the date on the level one administrative review decision notice by the department. The administrative reviewer shall be a department employee who has had no involvement in the matter under review.
 - (4) The reviewer for the level two administrative review shall evaluate all factors related to the department's eligibility decision and shall offer the filing unit the opportunity to have a personal conference with the administrative reviewer as part of the review process. Such personal conference may be conducted in person, by telephone or via video conferencing, at the option of the administrative reviewer. The administrative reviewer shall permit the filing unit to represent himself or herself or to have a representative of his or her choosing during the review process.
 - (5) The level two administrative reviewer shall render a decision in writing to the filing unit not later than forty-five (45) calendar days following the date of receipt of the filing unit's written request for the level two administrative review.
 - (6) The department shall conduct an expedited review within seventy-two (72) hours of the time an applicant requests external review, if the applicant's physician or health plan determines that operating under the standard review time frame could seriously

jeopardize the applicant's life or health or ability to attain, maintain or regain maximum function. If granted an expedited review, the department may take no longer than seventy-two (72) hours to make a decision. The department may extend the seventy-two (72) hour time frame by up to fourteen (14) calendar days, if the applicant requests an extension.

- (7) The commissioner may waive any of the time limits provided for in subdivision (1) to (6), inclusive, of this subsection.
 - (8) The department shall not grant an administrative review if the decision at issue is a provision in federal or state law requiring an automatic change in eligibility.
- (b) Continuation of benefits pending an administrative review
- (1) If an administrative review is requested within the time frames described in subsection (a) of this section, benefits shall continue at the level that existed prior to the request of the administrative review, until such time as the review process is complete.
 - (2) If the administrative review process is completed and the department prevails, reimbursement shall be required from the filing unit for any premiums that were not collected pending the outcome of the administrative review.

(NEW) Sec. 17b-311-7. Recovery

The department may recover any payments made on the behalf of an enrollee if such payment is based on the applicant failing to disclose or misrepresenting in any way, information requested by the department in order to determine eligibility.

(NEW) Sec. 17b-311-8. Rights and responsibilities

- (a) Rights
- (1) The applicant shall have the right to file an application for Charter Oak, to voluntarily withdraw the application at any time during the eligibility determination process, and to reapply after benefits have been discontinued.
 - (2) An enrollee shall have the right to have Charter Oak discontinued at any time, and the right to reapply for benefits after the discontinuance.
 - (3) The applicant or enrollee shall have the right to be treated fairly without regard to his or her race, color, religious creed, gender, sexual orientation, age, national origin, ancestry, mental retardation, mental disability, learning disability or physical disability, including, but not limited to, blindness as defined in 46a-71 of the Connecticut General Statutes.
 - (4) Spanish-speaking applicants and enrollees shall have the right to receive application and renewal forms and all notices in Spanish. The department or its agent shall provide services or information in person, in writing or by telephone for any applicant or filing unit representative with Limited English Proficiency, in accordance with Title VI of the Civil Rights Act of 1964.
 - (5) An applicant or enrollee with an impairment, such as a hearing or visual impairment shall have the right to auxiliary aids or other accommodations if he or she requests such accommodation.
 - (6) The applicant or enrollee shall have the right to be notified in writing of decisions made by the department.
 - (7) The applicant or enrollee shall have, within the timeliness standards established by the department, the right to request an administrative review in accordance with section 17b-311-6 of the Regulations of Connecticut State Agencies.
- (b) Responsibilities
- (1) The applicant shall be responsible for supplying the department, in an accurate and timely manner as determined by the department, all pertinent information and verification that the department needs to determine eligibility.

- (2) The enrollee shall have the responsibility to accurately report to the department any change that may affect eligibility not later than ten (10) calendar days after the date of the change.
- (3) The applicant and enrollee shall have the responsibility to cooperate with the department in completing eligibility determinations and renewals due to scheduled periodic reviews or unscheduled changes in circumstances that may affect eligibility.
- (4) The department shall process the application in a timely manner and shall inform the applicant when the department does not have sufficient information to make an eligibility decision.
- (5) The department shall maintain the confidentiality of all information received in conjunction with the eligibility process.
- (6) The department shall be responsible for allowing all filing unit members who are eighteen (18) years or older, United States Citizens, and residents of Connecticut the opportunity to register to vote at the time of application or renewal of eligibility and at the time a change of address is reported. In addition, the following conditions shall apply:
 - (A) the department is responsible for assisting the filing unit members in completing the registration form; and
 - (B) failure or refusal to register to vote does not affect eligibility for benefits.

(NEW) Sec. 17b-311-9. MCE enrollment requirements

- (a) Enrollees shall be required to enroll in a participating Charter Oak MCE in order to access the Charter Oak basic benefit package described in section 17b-311-11 of the Regulations of the Connecticut State Agencies.
- (b) When eligibility for Charter Oak has been determined, the department shall make available the following information to each filing unit and provide assistance to the filing unit concerning such information as needed:
 - (1) MCE choice options;
 - (2) Premiums, deductibles, co-payments, and co-insurance;
 - (3) lock-in requirements;
 - (4) MCE options for participating primary care providers including names and locations;
 - (5) disenrollment policies and procedures;
 - (6) types of benefits including amount, duration and scope of benefits available; and
 - (7) administrative review procedures.
- (c) The applicant shall complete and sign an enrollment form indicating his or her choice of MCE.
- (d) Individuals from the same filing unit, whether covered by HUSKY A, HUSKY B, or Charter Oak, shall be enrolled in the same MCE.
- (e) Nothing in this section shall prevent enrolling an eligible beneficiary in a MCE when such beneficiary is an inpatient of a hospital at the time of eligibility determination and initial enrollment in a MCE. The MCE chosen shall be responsible for such hospitalization from the effective date of enrollment in the MCE as determined in accordance with this section.
- (f) Enrollment date

An eligible beneficiary's effective date of enrollment in a MCE shall be determined in accordance with the specific requirements set forth in this subsection.

- (1) The monthly enrollment cut-off date for the purpose of determining the effective date of enrollment in a MCE for enrollees in Bands 1 through 4 shall be determined as follows:

- (A) enrollments completed on or before the fifteenth of the month shall have an enrollment date of the first day of the following month;
 - (B) enrollments completed after the fifteenth of the month through the last day of such month shall have an enrollment date of the first day of the second month.
- (2) Enrollees in Bands 1 through 4 shall be notified by the department, with reasonable prior notice, of the premium to be paid for the first month of coverage. Such notice shall contain:
- (A) the premium amount due and the premium due date;
 - (B) the effective date of disenrollment for non-payment of premium;
 - (C) information concerning the lock-out requirements as set forth in subsection (d) of section 17b-311-10 of the Regulations of the Connecticut State Agencies; and
 - (D) instruction to immediately contact the department if there has been a change in the filing unit's income or family size that may affect eligibility status.
- (3) For enrollees in Band 5 the enrollment date shall be:
- (A) the first day of the month directly following the month in which the enrollment is completed, provided the premium payment is received no later than the fifteenth of that preceding month; or
 - (B) the first day of the second month directly following the month in which the enrollment is completed, provided the premium payment is received after the fifteenth day of that preceding month.
- (4) For enrollees in Band 5, enrollment shall not be considered complete until the department receives payment of the premium for the beneficiary's initial month of coverage.
- (5) When the department receives a completed enrollment form from an eligible beneficiary in Band 5, the department shall immediately notify the MCE of the potential new member. The department shall also immediately notify the filing unit, with reasonable prior notice, of the premium to be paid for the first month of coverage. Such notice shall contain the premium amount due and the premium due date.
- (g) Enrollment after renewal
- (1) For individuals who choose to change MCEs as a result of the open enrollment period, the effective date of enrollment in such MCE shall be subject to the meeting the renewal requirements set forth in subsection (b) of section 17b-311-5 of the Regulations of the Connecticut State Agencies, and the following specific enrollment cut-off date requirements:
- (A) if the renewal requirements are met on or before the first day of the calendar month in which the eligibility period ends, the date of enrollment in the new MCE shall be the first day of the month following the month in which the open enrollment period ends; and
 - (B) if the renewal requirements are met after the first day of the calendar month in which the eligibility period ends, the date of enrollment in the new MCE shall be subject to the eligibility determination process set forth in subsection (a) of section 17b-311-5 of the Regulations of the Connecticut State Agencies and the enrollment date requirements set forth in subdivisions (1) to (3) of subsection (f) of this section.
- (2) For filing units who do not choose a new plan by the end of the open enrollment period, subject to the requirements set forth in subsection (h) of this section, the enrollee shall continue as a member of the same MCE.
- (3) If the filing unit does not meet the renewal requirements set forth in subsection (b) of section 17b-311-5 of the Regulations of the Connecticut State Agencies by the last day of the calendar month in which the filing unit's eligibility period ends, the enrollee shall be disenrolled from his or her current MCE. Subsequent re-enrollment shall be subject to such meeting the requirements set forth in subsection (a) of section 17b-311-5 of the

Regulations of the Connecticut State Agencies and the enrollment date requirements set forth in this subsection.

(h) Open enrollment period

Open enrollment is the sixty (60)-day period of time at the end of an eligibility period during which period the filing unit may choose a new MCE for any reason.

- (1) The open enrollment period shall end on the fifteenth day of the month in which the enrollee's current eligibility period ends.
- (2) For filing units who choose a new MCE as a result of the open enrollment period, the department shall provide reasonable prior notice of any premium to be paid for the first month of coverage. The prior notice shall contain:
 - (A) the premium amount due and the premium due date;
 - (B) the effective date of disenrollment for non-payment of premium;
 - (C) information concerning the lock-out requirements as set forth in subsection (d) of section 17b-311-10 of the Regulations of the Connecticut State Agencies; and
 - (D) instruction to immediately contact the department if there has been a change in the filing unit's income or family size that may affect eligibility status.

(i) Lock-in period

Lock-in shall occur at the time of initial enrollment in a MCE, subject to subsection (f) of this section, or subsequent annual renewal of eligibility. The last date of the lock-in period shall be the same date the eligibility period ends for the enrollee in such filing unit with the earliest date of enrollment in the MCE.

(j) Free-look period

Free-look period is the thirty (30)-day period of time, commencing on the date of onset of a lock-in period of the enrollee with the earliest date of enrollment in the MCE, during which a member, shall have the opportunity to choose a new MCE, provided no other household members are enrolled in a different MCE.

- (1) When an eligible beneficiary of a filing unit enrolls in the MCE subsequent to other existing members of such filing unit, there is no additional free-look period.
- (2) If a new MCE is not chosen during the free-look period, the filing unit shall remain in the MCE in which such filing unit is currently enrolled.
- (3) A change of MCE shall be allowed only once during any free-look period. Such change shall be subject to the specific requirements set forth in subdivisions (1) to (3), of subsection (f) of this section.
- (4) If a filing unit chooses a new MCE during the free-look period, the members of the filing unit shall remain in such MCE for the remainder of the lock-in period of such filing unit with the earliest date of enrollment in the MCE.

(NEW) Sec. 17b-311-10. MCE disenrollment

(a) An enrollee shall be disenrolled from a MCE under the following circumstances;

- (1) when the enrollee meets one of the criteria described in subsection (c) of section 17b-311-5;
- (2) for non-payment of premium in accordance with subsection (b) and (c) of this section;
- (3) disenrollment that meets the good cause requirements in accordance with subsection (f) of this section; or
- (4) when voluntary disenrollment is requested, subject to subdivision (2) of subsection (d) of this section; or

(b) Non-payment of premium

This subdivision sets forth the specific requirements for disenrollment due to non-payment of premium.

- (1) For Band 1 through 4 enrollees, the fifteenth day of the coverage month shall be designated as the payment due date. Premium payment shall be received by the department no later than the due date in order to forestall disenrollment. The effective date of disenrollment shall be the first of the month directly following the coverage month for which the premium was not paid.
- (2) For Band 5 enrollees, the fifteenth day of the month preceding the month covered by the premium shall be designated as the final date by which payment of a premium shall be received by the department in order to forestall disenrollment. The effective date of disenrollment shall be the first of the month covered by the unpaid premium.

(c) Notice of non-payment of premium

- (1) The requirements specified in this subdivision apply to enrollees in Band 1 through 4.
 - (A) Enrollees in Band 1 through 4 whose premium payment has not been received by the department by the last day of the month preceding the month to be covered by the unpaid premium shall be immediately notified in writing of the premium amount due. Such notice shall also contain:
 - (i) the final date for payment of the past due premium as set forth in subdivision (1) of subsection (b) of this section;
 - (ii) the effective date of disenrollment for non-payment of premium as set forth in subdivision (1) of subsection (b) of this section;
 - (iii) information concerning the lock-out requirements as set forth in subsection (d) of this section; and
 - (iv) instruction to immediately contact the department if there has been a decrease in the filing unit's income that may affect eligibility status.
 - (B) Enrollees in Bands 1 through 4 whose premium payment has not been received by the department by the fifteenth day of the coverage month shall be immediately notified in writing of the effective date of disenrollment for non-payment of premium. Such notice shall also contain:
 - (i) the effective date of disenrollment for nonpayment of premium as set forth in subdivision (1) of subsection (b) of this section;
 - (ii) information concerning the lock-out requirements as set forth in subsection (d) of this section; and
 - (iii) instruction to immediately contact the department if payment cannot be made by the date designated in subdivision (1) of subsection (b) of this section when due to a decrease in the filing unit's income that may effect eligibility status.
- (2) The requirements specified in this subdivision apply to those enrollees in Band 5.
 - (A) Enrollees in Band 5 whose premium payment has not been received by the department by the fifteenth day of the month preceding the month to be covered by the unpaid premium shall be immediately notified in writing of disenrollment by the MCE. Such notice shall contain:
 - (i) the premium amount due and the premium due date;
 - (ii) the effective date of disenrollment for non-payment of premium;
 - (iii) information concerning the lock-out requirements as set forth in subsection (d) of this section; and

- (iv) instruction to immediately contact the department if there has been a change in the filing unit's income or family size that may affect eligibility status.
- (B) Enrollees in Band 5 whose premium payment has not been received by the department by the last day of the month preceding the month to be covered by the unpaid premium shall be immediately notified in writing by the department of disenrollment. Such notice shall contain:
- (i) the effective date of disenrollment for non-payment of premium;
 - (ii) information concerning the lock-out requirements as set forth in subsection (d) of this section; and
 - (iii) instruction to immediately contact the department if there has been a change in the filing unit's income or family size that may affect eligibility status.
- (d) Lock-out
- (1) Non-payment of premium
- (A) Except as otherwise provided for in this subdivision, enrollees who are disenrolled from a MCE due to nonpayment of premium shall be locked out of participation in a MCE for three (3) consecutive calendar months beginning with the month in which disenrollment is effective.
- (B) An enrollee locked out of participation for nonpayment of premium may re-enroll in the MCE during the three (3) -month lock-out period if good cause for such re-enrollment exists.
- (C) Requests for early re-enrollment shall be sent in writing to the department. The department shall determine good cause. The circumstances that constitute good cause include, but are not limited to:
- (i) the enrollee documents a decrease in the filing unit's income that would affect the filing unit's premium status based on the requirements set forth in section 17b-311-14 of the Regulations of the Connecticut State Agencies; or
 - (ii) the filing unit documents an unexpected catastrophic financial liability.
- (D) In cases of the denial of a request for early re-enrollment, the eligible beneficiary may request an administrative review of such denial in accordance with section 17b-311-6 of the Regulations of the Connecticut State Agencies.
- (E) Upon expiration of a lock-out period, or approval of early re-enrollment for enrollees subject to this subdivision, the filing unit shall meet the following requirements in order to re-enroll in a MCE:
- (i) pay any past due premiums to the department which resulted in the current lock-out period; and
 - (ii) prepay the premium for the first month of re-enrollment to the department.
- (2) Voluntary disenrollment
- (A) Voluntary disenrollment occurs when enrollees do not have the approval of a good cause disenrollment under subsection (f) of this section, at the time the filing unit elects to disenroll the beneficiary from a MCE.
- (B) Enrollees who are in a lock-in period at the time of disenrollment under subsection (i) of section 17b-311-9 of the Regulations of the Connecticut State Agencies shall be locked out from participation in a MCE for three (3) consecutive calendar months beginning with the month in which disenrollment is effective.

- (C) Enrollees who disenroll under this subdivision may request re-enrollment prior to the end date of the lock-out period if they meet the criteria for early re-enrollment set forth in subsection (f) of this section.
- (3) Enrollees who meet the requirements of this subsection shall be re-enrolled in the same MCE if such beneficiary is in a lock-in period at the time of the lock-out end date.
- (4) For enrollees subject to this subdivision whose filing unit is in Band 5, re-enrollment shall be subject to prior payment of the premium for the beneficiary's first month of coverage subsequent to the lock-out period.
- (5) For enrollees who meet the requirements for lock-out as set forth in this subsection, the department shall notify the filing unit in writing concerning:
 - (A) a reason for the lock-out;
 - (B) the effective date and term of the lock-out period; and
 - (C) the criteria for good cause early re-enrollment;
- (6) If an enrollee is in a lock-out period, and also in an open enrollment period, or not otherwise in a lock-in period, the filing unit may choose a new MCE.
- (7) Re-enrollment into a MCE for enrollees who complete their renewal while in a lock-out period shall not occur until the end of such lock-out period.
- (8) Members who are in a lock-out period and also in a lock-in period, but not in an open enrollment period, at the time of re-enrollment, shall be required to re-enroll into the same MCE they were locked into prior to such lock-out, provided all requirements for such enrollment having been met as set forth in this subsection.
- (e) The effective date of re-enrollment into a MCE shall be subject to the requirements set forth in subsection (f) of section 17b-311-9 of the Regulations of the Connecticut State Agencies.
- (f) Good cause disenrollment
 - (1) A filing unit may request a change of MCE for good cause. The determination of good cause in this case shall be made by the department. Such request shall be submitted in writing to the department citing any of the following reasons as the basis for requesting such disenrollment:
 - (A) the filing unit received an unfavorable resolution of his or her complaint through the MCE's internal complaint process and there is continued dissatisfaction due to repeated incidents of the following:
 - (i) documented long waiting times for an enrollee's provider appointments. The following are considered long waiting times; more than forty-five (45) days for well-child visits; more than ten (10) days for non-urgent, symptomatic office visits; more than two (2) days for urgent visits; unavailability of same day office visit or unavailability of same day referral to an emergency provider for emergency care services;
 - (ii) documented inaccessibility of the enrollee's MCE by phone or mail. The following circumstances shall constitute lack of access to the MCE: phone calls are not answered promptly; the caller is placed on hold for an extended period of time; or phone messages or letters are not responded to promptly; or
 - (iii) rude and demeaning treatment of the enrollee by MCE staff; or
 - (B) prior to a MCE internal appeal process, or without filing an appeal through the MCE, there is dissatisfaction due to any of the following reasons:
 - (i) discriminatory treatment as documented in a complaint filed with the Commission on Human Rights and Opportunities or the department's affirmative action division;

- (ii) the enrollee's PCP is unable to serve the enrollee's specific documentable needs. Such circumstances shall include, but are not limited to: the enrollee's language or physical accessibility needs; or the PCP is no longer in the MCE's provider network and there is no other suitable PCP within a reasonable distance to the enrollee's home in the MCE's provider network who can meet the enrollee's needs; or
 - (iii) the filing unit has provided documentation to the department of such filing unit representative's pending lawsuit against the enrollee's MCE.
- (2) A MCE may initiate a request to disenroll an enrollee for good cause when the MCE has documented evidence that the enrollee's MCE membership card was fraudulently loaned to another person for the purposes of obtaining services under the card by such person. The determination of whether to disenroll an enrollee in this case shall be made by the department subject to the following conditions:
 - (A) The MCE shall submit a request to disenroll an enrollee in writing to the department;
 - (B) The request shall cite the specific event(s), date(s) and other pertinent information substantiating the MCE's request; and
 - (C) the MCE shall submit any other information concerning the MCE's request that the department may require in order to make a determination in the case.
- (3) In cases of the denial of the request under subdivision (1) of this subsection, or approval of the request under subdivision (2) of this subsection, the filing unit may request an administrative review of the decision in accordance with section 17b-311-6 of the Regulations of Connecticut State Agencies.
- (4) Filing units whose MCE is changed in accordance with subdivision (1) of this subsection shall not be subject to lock-out.
- (g) Disenrollment during hospitalization

This subsection sets forth the specific requirements for payment related to coverage for members who are disenrolled from a MCE while hospitalized.

- (1) Except as provided in subdivision (5) of this subsection, the MCE shall be responsible for providing continuous coverage for an inpatient hospital stay when the primary diagnosis is medical, up to the point of discharge, for any enrollee who was admitted as an inpatient while enrolled in such MCE and if the enrollee is disenrolled from the MCE for any reason during the same inpatient admission.
- (2) The continuation of payment by the MCE following disenrollment shall only pertain to the daily inpatient rate charged by such hospital providing the enrollee's inpatient care.
- (3) In the event an enrollee changes MCE while hospitalized, as provided for in subsection (e) of section 17b-311-9 of the Regulation of the Connecticut State Agencies, the enrollee's new MCE shall be responsible for all charges, except as provided for in subdivision (2) of this subsection, which are incurred incident to such hospital stay, beginning with the effective date of enrollment in such MCE.
- (4) When an enrollee changes MCEs while hospitalized, both the enrollee's outgoing MCE and new MCE shall effectively coordinate the transfer of essential clinical information regarding the enrollee's inpatient care in a timely manner. The outgoing MCE shall also participate in the coordination of the discharge planning process with the new MCE and the hospital as necessary.
- (5) If a member is disenrolled while hospitalized and the primary diagnosis for the admission is behavioral, there shall not be continuous coverage for the inpatient hospital stay. The payment for such hospitalization will end on the effective date of disenrollment.

(NEW) Sec. 17b-311-11. Basic benefit package

- (a) The goods and services set forth in this section are contained in the Charter Oak basic benefit package.

- (b) The benefits set forth in subsection (d) of this section shall not be subject to the application of a pre-existing condition exclusion;
- (c) The member shall be responsible for payment to the provider of the amount of cost for an item or service in excess of the amount of allowance stipulated in this section or in excess of the maximums established in section 17b-311-15 of the Regulations of Connecticut State Agencies.
- (d) Basic benefit package

At a minimum, the following medically necessary goods and services are covered, subject to the limitations specified in this section and in section 17b-311-15 of the Regulations of Connecticut State Agencies. The limitations specified in this subsection shall apply on an annual basis starting from the first day of the enrollee's eligibility period, regardless of the number of times the enrollee changes MCEs during such period.

- (1) Preventive care and services, including:
 - (A) Well-care visits;
 - (B) Immunizations;
 - (C) Health screenings;
 - (D) Routine laboratory tests;
 - (E) Prenatal care, including care of all complications of pregnancy;
 - (F) Assessments required under sections 17a-106a and 46b-129a of the Connecticut General Statutes;
- (2) Family planning and reproductive health services, including:
 - (A) reproductive health exams;
 - (B) patient counseling;
 - (C) patient education;
 - (D) lab tests to detect the presence of conditions affecting reproductive health;
 - (E) screening, testing and treatment of and pre and post-test counseling for sexually transmitted diseases and human immunodeficiency virus (HIV); and
 - (F) abortion.
- (3) Inpatient and outpatient physician visits;
- (4) Inpatient hospital care;
- (5) Behavioral health benefits under Charter Oak shall be administered in the same manner as the Connecticut Behavioral Health Partnership, except as follows:
 - (A) An ASO shall be responsible for the activities and functions provided for in section 17a-22a-4 of the Regulations of Connecticut State Agencies, but may not include all of the activities and functions described in subsections (d),(f), (h), and (k) of said section;
 - (B) Covered services as established in section 17a-22a-5 of the Regulations of Connecticut State Agencies shall not include:
 - (i) rehabilitation services except to the extent that such services are provided as an integral part of clinic-based intermediate care programs;
 - (ii) case management services;
 - (iii) psychiatric residential treatment facility services;
 - (iv) methadone maintenance services;

- (v) EPSDT special services; and
 - (vi) residential and community services funded by the Connecticut Department of Children and Families.
- (C) Covered psychiatric services as established in section 17a-22a-5 of the Regulations of Connecticut State Agencies shall also be subject to the following limitations and cost-sharing:
- (i) Inpatient hospital services shall be subject to co-insurance, as established in section 17b-311-13 of the Regulations of Connecticut State Agencies, and deductible and co-insurance maximums, as established in section 17b-311-14 of the Regulations of Connecticut State Agencies;
 - (ii) Home health services are limited to medication administration and shall be limited to thirty (30) visits per benefit year; and
 - (iii) Outpatient and intermediate care services shall be subject to a co-payment per visit, as established in section 17b-311-13 of the Regulations of Connecticut State Agencies.
- (D) Covered substance abuse services as established in section 17a-22a-5 of the Regulations of Connecticut State Agencies shall also be subject to the following limitations and cost-sharing:
- (i) Inpatient hospital and residential detoxification services shall be subject to co-insurance, as established in section 17b-311-13 of the Regulations of Connecticut State Agencies, and deductible and co-insurance maximums, as established in section 17b-311-14 of the Regulations of Connecticut State Agencies;
 - (ii) Inpatient hospital and residential detoxification services for drug-related conditions shall be limited to twenty (20) days per benefit year;
 - (iii) Inpatient hospital and residential detoxification services for alcohol-related conditions shall be limited to fifteen (15) days per benefit year;
 - (iv) Ambulatory services including all non-inpatient services provided by hospitals, freestanding clinics, and independent practitioners shall be subject to an aggregate limit of thirty (30) visits (i.e., thirty (30) visits across all of the aforementioned service types) per benefit year; and
 - (v) Outpatient and intermediate care services shall be subject to a co-payment per visit, as established in section 17b-311-13 of the Regulations of Connecticut State Agencies.
- (E) The client appeals process shall be as for HUSKY B enrollees, as described in section 17a-22a-15 of the Regulations of Connecticut State Agencies.
- (6) Hospice care;
- (A) Coverage provided to members who are diagnosed as having a terminal illness with a life expectancy of six (6) months or less.
 - (B) Covered care includes:
 - (i) nursing care;
 - (ii) physical therapy;
 - (iii) speech therapy;
 - (iv) medical social work;
 - (v) home health aids and homemakers;
 - (vi) medical supplies;

- (vii) drugs;
 - (viii) appliances;
 - (ix) durable medical equipment (DME);
 - (x) physician services;
 - (xi) occupational therapy;
 - (xii) short-term inpatient care, including, but not limited to respite care;
 - (xiii) care for pain control and acute chronic symptom management;
 - (xiv) services of volunteers; and
 - (xv) other benefits when ordered by a physician.
- (C) Limitations on short-term rehabilitation do not apply.
- (7) Outpatient surgical facility;
- (8) The pharmacy drug benefit shall be subject to co-payment and a \$7,500 maximum benefit per benefit year. The department shall administer the pharmacy drug benefit in the same manner as the Medicaid program as to covered drugs and prior authorization process, including temporary supply. For pharmacy drugs for which coverage is denied, a member can request a desk review from the department. A request for such review must be received in writing by the department not later than twenty (20) days from the date the department mails the denial notice. Members who have exhausted the department's review process and are not satisfied with the department's decision which involves a determination of medical necessity may file an appeal with the Department of Insurance pursuant to section 38a-478n of the 2008 Supplement to the General Statutes. The department shall pay the filing fee required under said section on behalf of enrollees in Band 1, 2, 3, and 4. Enrollees in Band 5 shall be responsible for the payment of the filing fee.
- (9) Home health care for homebound enrollees, except for:
- (A) custodial care;
 - (B) homemaker care; and
 - (C) care that may be provided in a medical office, hospital or skilled nursing facility and offered to a member in such setting.
- (10) Short-term rehabilitation, for conditions where significant improvement is expected within sixty (60) days. The coverage of short-term rehabilitation is limited to thirty (30) visits per benefit year. Short-term rehabilitation includes, but is not limited to:
- (A) physical therapy;
 - (B) speech therapy;
 - (C) occupational therapy; and
 - (D) skilled nursing care, but excluding private duty nursing.
- (11) Laboratory and radiology;
- (12) Radiation therapy;
- (13) Chemotherapy;
- (14) Hemodialysis;
- (15) Pre-admission testing;

- (16) Urgent care;
 - (17) Emergency care, including, but not limited to, emergency care provided while the member is out of the state of Connecticut, and emergency care received while outside the country;
 - (A) A co-payment is required if the care is determined not to be an emergency.
 - (B) The co-payment shall be waived if the patient is admitted.
 - (18) Ambulance, when determined to be an emergency;
 - (19) Durable Medical Equipment (DME), except for power wheelchairs. Each member shall be limited to a maximum annual benefit of \$4,000 for DME. The calculation of the maximum annual benefit for DME shall not include any payments made for diabetic and ostomy supplies that are considered DME.
 - (20) Diabetic and ostomy medical and surgical supplies;
 - (21) Prosthetics devices, whether worn anatomically or surgically implanted, which replace all or part of a body organ or structure and which correct, strengthen or provide necessary support to the body. Orthopedic shoes, foot orthotics, wigs or hairpieces are not covered.
 - (22) Hearing exam;
 - (23) Nurse midwives;
 - (24) Nurse practitioners;
 - (25) Podiatry, except for:
 - (A) routine foot care rendered:
 - (i) in the examination, treatment or removal of all or part of corns, callosities, hypertrophy or hyperplasia on the skin or subcutaneous tissue of the foot; and
 - (ii) in the cutting, trimming or other non-operative partial removal of toenails, except when medically necessary in the treatment of neuro-circulatory conditions.
 - (26) Modified food products and nutritional formulas, limited to medically necessary amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases when ordered by a participating physician.
 - (27) Services related to dental emergency medical conditions or facial trauma provided in a hospital or other emergency care setting;
 - (28) Oral surgery services performed by an oral and maxillofacial surgeon, except:
 - (A) services relating to and including implant placement; and
 - (B) tooth extraction, unless such extraction is performed in conjunction with disease states or trauma that requires corrective procedures to be performed in the operating room, or is of an impacted third molar or a third molar causing pathological conditions.
 - (29) Inpatient Rehabilitation/Skilled Nursing Facility coverage shall be limited to fourteen (14) days per benefit year unless it is documented to be a cost-effective alternative in lieu of hospitalization. The MCE shall submit documentation of cost-effectiveness to the department, which shall have sole discretion to determine cost-effectiveness on a case-by-case basis.
- (e) Additionally, the following goods and services are not covered under the Charter Oak basic benefit package:

- (1) Those that are provided while the enrollee is out of the state of Connecticut, except for emergency care provided within or outside of the United States or services prior authorized by the department and provided within the United States;
- (2) Those that are furnished by a provider who is not a member of the enrollee's provider network at the time of the service for which prior authorization was not obtained, except for emergency care;
- (3) Those for which prior authorization is required and is not obtained;
- (4) Treatment of infertility;
- (5) Those that are considered to be of an unproven, experimental or research nature, or cosmetic, social, habilitative, vocational, recreational or educational;
- (6) Those that are otherwise covered in section 17b-311-11 of the Regulations of Connecticut State Agencies, which are determined by the department not to be medically necessary, except that an enrollee shall have the right to appeal such determination, as provided for in section 17b-311-17 of the Regulations of Connecticut State Agencies;
- (7) Those that are required by third parties, such as school or employment physicals, physicals for summer camp, enrollment in health, athletic or similar clubs, premarital blood work or physicals, or physicals required by insurance companies or court ordered alcohol or drug abuse courses;
- (8) Cosmetic and reconstructive surgery, except when surgery is required for:
 - (A) reconstructive surgery in connection with the treatment of malignant tumors or other destructive pathology that causes dysfunction;
 - (B) reduction mammoplasty in females when medically necessary and breast surgery in males only in cases of suspected malignancy. Surgery shall be necessary to achieve normal physical or bodily function;
- (9) Evaluation, treatment and procedures related to, and the performance of, sexual reassignment surgery;
- (10) Surgical treatment or hospitalization for the treatment of morbid obesity except where prior authorized as medically necessary;
- (11) Care, treatment, procedures, services or supplies that are primarily for dietary control, including, but not limited to, any exercise or weight reduction programs, whether formal or informal, and whether or not recommended by an in-network physician or an out-of-network physician;
- (12) Acupuncture, biofeedback or hypnosis;
- (13) Treatment at pain clinics unless determined to be medically necessary;
- (14) Ambulatory blood pressure monitoring;
- (15) Any court ordered testing, diagnosis, care or treatment deemed not medically necessary;
- (16) Dental care;
- (17) Vision care;
- (18) Chiropractic care; and
- (19) Naturopaths.

(NEW) Sec. 17b-311-12. Premium requirements

The applicability of premiums shall be determined in accordance with the requirements specified in subsections (a) and (b) of this section.

- (a) The amount a member shall pay in premiums for the Charter Oak basic benefit package shall vary according to the filing unit's income as follows:

- (1) if the filing unit is in income Band 1, 2, 3, or 4, as determined in accordance with section 17b-311-3 of the Regulations of Connecticut State Agencies, the member shall pay a premium determined by the Commissioner, which shall represent a rate partially subsidized by the department for each enrollee in Charter Oak; or
 - (2) if the filing unit is in income Band 5, as determined in accordance with section 17b-311-3 of the Regulations of Connecticut State Agencies, the member shall pay a premium determined by the Commissioner, which shall represent a rate that is not subsidized by the department for each enrollee in Charter Oak. Such premium amount for this income group may vary based on the MCE selected.
- (b) The department may accept funds from private or tribal organizations for the purpose of subsidizing the payment of premiums.
- (c) The department shall bill the filing unit or a designated alternate payor for the premium payments and collect such payments from the filing unit or payor. Filing units may be billed up to thirty (30) days in advance of the coverage period. Such billing shall occur no less than monthly.

(NEW) Sec. 17b-311-13. Co-payment and co-insurance requirements

- (a) The Commissioner shall establish a schedule of reasonable co-payments, which the member shall be required to pay. Such co-payments shall apply to goods and services covered in the basic benefit package, including, but not limited to, the following goods and services:
- (1) non-preventive outpatient clinician visits;
 - (2) behavioral health outpatient and intermediate care visits;
 - (3) outpatient rehabilitation;
 - (4) urgent care;
 - (5) prescription drugs, generic and brand names; and
 - (6) care provided in an emergency department that is not determined an emergency.
- (b) The Commissioner shall establish a schedule of reasonable co-insurance. The member shall be required to pay such co-insurance, subject to section 17b-311-14 of the Regulations of the Connecticut State Agencies. Such co-insurance shall apply to goods and services covered in the basic benefit package, including, but not limited to, the following goods and services:
- (1) ambulatory surgery;
 - (2) inpatient hospital admissions, including psychiatric and substance abuse-related admissions;
 - (3) residential detoxification services for substance abuse;
 - (4) inpatient rehabilitation/skilled nursing facility admissions; and
 - (5) outpatient laboratory and radiology.
- (c) No co-payment or co-insurance shall be charged for the following basic benefits:
- (1) primary care provider visits for preventive care;
 - (2) family planning and reproductive health visits for preventive care;
 - (3) pre- and post-natal care visits;
 - (4) specialist physician visits for second opinions;
 - (5) ambulance services for emergency medical conditions; and
 - (6) emergency care that is determined to be for an emergency medical condition or that results in an inpatient admission.

(NEW) Sec. 17b-311-14. Deductibles and co-insurance maximums

- (a) The commissioner shall establish annual deductible and co-insurance maximum amounts for members in each income band, as established in section 17b-311-3 of the Regulations of Connecticut State Agencies. The member shall be required to pay such deductible and co-insurance amounts, should he or she incur expenses as set forth in this section. The deductible and co-insurance maximum shall apply on an annual basis starting from the first day of the eligibility period of the filing unit member with the earliest date of enrollment in Charter Oak, regardless of the number of times the enrollee changes MCEs during such period.
- (b) Deductibles and co-insurance maximums apply only to services that are subject to co-insurance, as established in subsection (b) of section 17b-311-13 of the Regulations of Connecticut State Agencies.
- (c) Only payments that are made by members for services that are subject to co-insurance, as established in subsection (b) of section 17b-311-13 of the Regulations of Connecticut State Agencies, are included in determining whether the deductible and co-insurance maximum have been met. The co-insurance maximum only includes co-insurance payments made by the member after the deductible has been met.
- (d) Charter Oak shall not cover services that are subject to co-insurance, as established in subsection (b) of section 17b-311-13 of the Regulations of Connecticut State Agencies, prior to the member incurring the costs for an amount of services equal to the full deductible amount. The member shall pay for an amount of services equal to the deductible amount. Once the deductible amount has been incurred, the member incurs the applicable co-insurance amount upon receiving services that are subject to co-insurance. Charter Oak shall cover the portion of the costs for those services the member is not required to pay, until the member has incurred the applicable co-insurance maximum. Once both the deductible and co-insurance maximum amounts have been incurred by the member, coverage for services that are subject to co-insurance, as established in subsection (b) of section 17b-311-13 of the Regulations of Connecticut State Agencies, is paid without further member contribution, subject to the benefit maximums established in section 17b-311-15 of the Regulations of Connecticut State Agencies.
- (e) The department shall inform the member or filing unit in writing and orally, if appropriate, of its deductible and co-insurance maximum amount at the time of enrollment and reenrollment.
- (f) The department shall monitor the annual aggregate cost sharing amounts from deductible and co-insurance payments that a filing unit has incurred in order to ensure that such aggregate amounts do not exceed the applicable maximums.
- (g) If the deductible or co-insurance maximum amount is exceeded, the department shall, at the time of determination of such overpayment, immediately notify the member and the entity that received such overpayment to refund to the member the amount in excess of such limit.

(NEW) Sec. 17b-311-15. Annual and lifetime benefit maximums

- (a) Each member shall be limited to a maximum annual benefit of \$100,000 for all goods and services covered by Charter Oak. The calculation of the maximum annual benefit shall not include any cost-sharing payment made by the member. The maximum annual benefit shall apply on an annual basis starting from the first day of the enrollee's eligibility period.
- (b) Each member shall be limited to a maximum lifetime benefit of \$1,000,000 for all goods and services covered by Charter Oak. The calculation of the maximum lifetime benefit shall not include any cost-sharing payment made by the member.
- (c) Members shall have the right to an administrative review concerning a decision by the department that they have reached their maximum annual or lifetime dollar benefit amounts, as established in subsections (a) and (b) of this section and subdivisions (8) and (19) of subsection (d) of section 17b-311-11 of the Regulations of Connecticut State Agencies. Such administrative review shall be conducted in accordance with the process established under subsection (a) of section 17b-311-6 of the Regulations of Connecticut State Agencies.

(NEW) Sec. 17b-311-16. Prior authorization requirements

The department shall act upon requests for prior authorization of services covered under the Charter Oak basic benefit package not later than fourteen (14) days after receipt of a request for services, or an additional fourteen (14) days if the member or provider requests an extension or the MCE, department, or health care provider needs the extension to obtain additional information. An expedited prior

authorization process shall be available when a provider indicates, or MCE or department determines, that the timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. Prior authorization shall be based on individual care plans and medical necessity and medical appropriateness. The following services in the basic benefit package shall not require prior authorization:

- (1) preventive care, including:
 - (A) periodic well-care visits;
 - (B) immunizations;
 - (C) prenatal care;
- (2) Family planning and reproductive health services, including:
 - (A) reproductive health exams;
 - (B) member counseling;
 - (C) member education;
 - (D) lab tests to detect the presence of conditions affecting reproductive health; and
 - (E) screening, testing and treatment of and pre and post-test counseling for sexually transmitted diseases and HIV;
- (3) emergency ambulance services or emergency care; and
- (4) diabetic and ostomy supplies that are DME.

(NEW) Sec. 17b-311-17. Appeal process requirements

- (a) MCE appeals process
 - (1) A member shall have the right to appeal a MCE decision regarding the denial of services covered in the basic benefit package administered by the MCE. The appeal shall be received not later than sixty (60) days from the date the MCE mails the denial notice.
 - (2) The denial notice shall contain the following information:
 - (A) the services that are being denied;
 - (B) the reason for the denial;
 - (C) the section of the Regulations of the Connecticut State Agencies that supports the denial;
 - (D) the right to challenge the denial by filing an internal appeal;
 - (E) the procedures and timeframe for each level of the MCE's internal appeal process;
 - (F) the availability of expedited internal appeals;
 - (G) the external appeal process available through the Department of Insurance;
 - (H) a statement that the member may submit additional information in support of the appeal;
 - (I) a statement that the MCE's review may be based on written information available to the MCE, unless the member requests a meeting or the opportunity to submit additional information; and
 - (J) any other information specified by the department.
 - (3) The MCE shall have internal appeal procedures for receiving and acting upon such appeals.

- (A) The internal appeal process may consist of more than one level of review.
 - (B) The MCE shall provide for an expedited internal appeal process when the standard timeframes for determining an appeal could jeopardize the life or health of the member or the member's ability to regain maximum functioning.
 - (C) A MCE representative having final decision-making authority shall conduct the final level of the MCE review. One or more physicians who were not involved in the decision under review shall decide any appeal arising from an action based on a determination of medical necessity.
 - (D) The MCE shall be responsible for ensuring compliance with the internal appeal process requirements, whether the goods or services are denied by the MCE or one of its subcontractors.
- (4) The MCE shall notify the member in writing of its internal appeal decision. The written decision shall include a clear statement of the MCE's disposition of the appeal, a statement that the enrollee has exhausted the MCE's internal appeal procedures and that the member has the right to an external appeal of any decision based upon medical necessity. The decision shall be sent to the member not later than thirty (30) days from the date the MCE received the appeal.
 - (5) Members who have exhausted the MCE internal appeal process and are not satisfied with a MCE decision which involves a determination of medical necessity may file an appeal with the Department of Insurance pursuant to section 38a-478n of the 2008 Supplement to the General Statutes. The department shall pay the filing fee required under said section on behalf enrollees in Band 1, 2, 3, and 4. Enrollees in Band 5 shall be responsible for the payment of the filing fee.
- (b) Behavioral health appeals process

The process for appealing a denial of services for behavioral health benefits shall be as established in subdivision (5) of subsection (d) of section 17b-311-11 of the Regulations of Connecticut State Agencies
 - (c) Pharmacy appeals process

The process for appealing a denial of service for pharmacy benefits shall be as established in subdivision (8) of subsection (d) of section 17b-311-11 of the Regulations of Connecticut State Agencies

(NEW) Sec. 17b-311-18. Quality assurance

- (a) The department shall establish and update standards to oversee and ensure the quality of care provided under Charter Oak.
- (b) The MCEs shall establish a written comprehensive internal quality assurance plan.

(NEW) Sec. 17b-311-19. Provider network

MCEs shall have a comprehensive provider network, subject to the criteria and requirements established by the department in its contracts with the MCEs, that assures the delivery or arrangement for the delivery of the Charter Oak basic benefit package, including, but not limited to, access to out-of-network providers when the network is not adequate for the enrollee's medical condition, to meet the health needs of all enrollees enrolled in the MCE.

(NEW) Sec. 17b-311-20. Dental or vision riders

Each MCE may offer its members an elective supplemental rider providing dental or vision coverage, subject to the Commissioner's approval of its terms.

Statement of Purpose: To adopt regulations to administer the Charter Oak Health Plan, which provides access to health insurance coverage for adult state residents who have been uninsured for at least six (6) months and who are ineligible for other publicly funded health insurance plans. The program consists of health coverage without consideration of pre-existing conditions. Medical services are administered

through managed care entities. Behavioral health services for Charter Oak members are administered separately, through an ASO.

The regulations contain eligibility and other program requirements for adults to be enrolled in a managed care entity. Charter Oak offers coverage on both a subsidized and non-subsidized basis, depending on household income. The regulations set forth the premium and other cost-sharing requirements. The regulations specify the health benefits covered by Charter Oak, limitations on those benefits and specific services excluded from coverage.