



General Assembly

January Session, 2007

Amendment

LCO No. 8085

HB0665208085HDO

Offered by:

REP. O'CONNOR, 35th Dist.

REP. CHRIST, 11th Dist.

REP. SCHOFIELD, 16th Dist.

REP. HEINRICH, 101st Dist.

To: Subst. House Bill No. 6652

File No. 831

Cal. No. 228

"AN ACT ESTABLISHING THE CONNECTICUT HEALTHY STEPS PROGRAM."

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

3 "Section 1. (NEW) (*Effective July 1, 2007*) Sections 1 to 9, inclusive, 12,
4 15 to 26, inclusive, 32, 35 to 38, inclusive, and 42 of this act, and
5 subsection (a) of section 12-202a, sections 12-296 and 12-316,
6 subdivision (37) of subsection (a) of section 12-407, sections 17b-192,
7 17b-261, 17b-267, 17b-277, 17b-292, 17b-297, 17b-297b, 38a-482, 38a-497,
8 38a-554 and 38a-567 of the general statutes shall be known as the
9 Connecticut Healthy Steps Program.

10 Sec. 2. (NEW) (*Effective July 1, 2007*) (a) There is established a
11 permanent Health Care Reform Commission, which shall be an
12 independent nonprofit body within the Office of Health Care Access

13 for administrative purposes only. The commission shall consist of the
14 Comptroller, the Commissioners of Social Services, Public Health,
15 Education and Health Care Access, the Insurance Commissioner, or
16 their designees, and nine additional members as follows: One member
17 to be appointed by the Governor, two to be appointed by the president
18 pro tempore of the Senate, two to be appointed by the speaker of the
19 House of Representatives, one to be appointed by the majority leader
20 of the Senate, one to be appointed by the majority leader of the House
21 of Representatives, one to be appointed by the minority leader of the
22 Senate, and one to be appointed by the minority leader of the House of
23 Representatives.

24 (b) Notwithstanding the provisions of subsection (c) of section 4-9a
25 of the general statutes, the members of the commission shall serve for
26 staggered terms. The initial members selected shall serve as follows: (1)
27 The members appointed by the Governor and the president pro
28 tempore of the Senate shall serve for three years; (2) the members
29 appointed by the speaker of the House of Representatives and the
30 majority leader of the Senate shall serve for two years; and (3) the
31 members appointed by the majority leader and the minority leader of
32 the House of Representatives and the minority leader of the Senate
33 shall serve for one year. Following the expiration of such initial terms,
34 each subsequent appointee shall serve for a term of three years. Any
35 vacancy shall be filled by the appointing authority for the unexpired
36 portion of the term of the member replaced. The members shall serve
37 without compensation for their services but shall be reimbursed for
38 their expenses.

39 (c) The commission shall: (1) Not later than April 1, 2008, develop
40 affordable health care plans that may be sold to individuals and to
41 employers of fifty or fewer employees through the Connecticut
42 Connector as administered in accordance with section 3 of this act, and
43 not later than January 1, 2009, make such plans available for sale, and
44 if any such employer purchases an affordable health care plan through
45 the Connecticut Connector for its employees or purchases any other
46 plan through such connector or any other person for its employees that

47 is at least actuarially equivalent to the affordable health care plans,
48 such employer shall qualify for a tax credit pursuant to section 38 of
49 this act, (2) not later than October 1, 2009, submit a report to the joint
50 standing committee of the General Assembly having cognizance of
51 matters relating to insurance that identifies the effect of health
52 insurance mandates under chapter 700c of the general statutes on
53 health care premiums paid by private sector employers, (3) develop
54 incentives to encourage individuals to use health insurance
55 responsibly, (4) determine if insurance producers should be paid a fee
56 for making referrals to the Connecticut Connector as administered in
57 accordance with section 3 of this act, and if so, the amount of such fee,
58 (5) not later than January 1, 2008, plan for the implementation of a
59 pharmaceutical purchasing pool to be administered by a third-party
60 administrator to cover all public agencies that provide or purchase
61 prescription drugs, except the Department of Social Services for the
62 Medicaid program and the Comptroller for the group hospitalization
63 and medical and surgical plan or plans for state employees, (6) not
64 later than July 1, 2008, establish the Connecticut Health Quality
65 Partnership under section 19 of this act, (7) perform the duties as
66 required under section 20 of this act, (8) not later than April 1, 2008,
67 develop a plan for the (A) collection of premium from individuals and
68 employers purchasing coverage through the Connecticut Connector as
69 administered in accordance with section 3 of this act, (B) imposition of
70 penalties for late payment of premium, and (C) termination of
71 coverage for nonpayment of premium, and (9) not later than January 1,
72 2009, and annually thereafter, make recommendations to the General
73 Assembly concerning the implementation of the Connecticut Healthy
74 Steps Program and improvements to the health care system, including
75 cost controls.

76 (d) The commission shall meet as often as necessary to complete its
77 work, but not less than quarterly each year. The commission, within
78 available appropriations, may hire consultants and staff, who shall not
79 be employees of the state, to provide assistance with its
80 responsibilities.

81 Sec. 3. (NEW) (*Effective July 1, 2007*) (a) Not later than October 1,
82 2007, the Insurance Department, in consultation with the Health Care
83 Reform Commission, shall award a five-year contract to administer the
84 Connecticut Connector to the Health Reinsurance Association
85 established in section 38a-556 of the general statutes.

86 (b) Such association administering the Connecticut Connector shall
87 meet with the Health Care Reform Commission in accordance with a
88 schedule the commission determines to be appropriate.

89 (c) Such association shall perform the following duties:

90 (1) Solicit insurers to make products available for sale through the
91 Connecticut Connector;

92 (2) Review the products for compliance with benefit and other
93 standards as established by the Health Care Reform Commission;

94 (3) Publish easy to understand materials for prospective purchasers,
95 comparing the costs and benefits of all plans and providing counseling
96 to assist in plan selection;

97 (4) Screen applicants consisting of individuals and employers for
98 eligibility to purchase through the pool;

99 (5) Screen applicants consisting of individuals for eligibility for the
100 programs established under sections 8 and 9 of this act;

101 (6) Work with the insurers selling products through the Connecticut
102 Connector to develop and adopt a uniform tool for collecting necessary
103 applicant or enrollee data for any appropriate underwriting,
104 enrollment and other purposes;

105 (7) Collect premium contributions from employers and individuals,
106 as well as subsidies from the state, and remit them to the enrollees'
107 health plans;

108 (8) Collect fees from all insurers and health care centers licensed in

109 the state to sell individual health insurance policies or group health
110 insurance plans covering eligible employees of one or more small
111 employers, excluding the Medicaid managed care health plans, in
112 accordance with rules adopted by the Health Care Reform
113 Commission, to support the costs of administration;

114 (9) Notify insureds when their premiums are late and disenroll
115 them or levy late penalties as appropriate;

116 (10) Provide notices as required under the Health Insurance
117 Portability and Accountability Act of 1996, (P.L. 104-191) (HIPAA), as
118 from time to time amended, regarding creditable coverage;

119 (11) Market the health plans available through the Connecticut
120 Connector to potential purchasers of the health plans through the use
121 of the following, including, but not limited to, advertising, public
122 information campaigns, and outreach through the Medicaid and other
123 publicly funded health programs, through the chambers of commerce
124 or other trade or professional associations or through health care
125 providers;

126 (12) Provide information to applicants who may be eligible for the
127 Medicaid program or the HUSKY Plan, Part A and Part B, as to how
128 and where to apply for such programs;

129 (13) Provide information regarding Health Reinsurance Association
130 benefits to applicants who are denied coverage due to underwriting
131 concerns;

132 (14) Provide counseling to applicants to assist them in
133 understanding their options and to select the option that reflects their
134 needs and income;

135 (15) Develop a standardized application form and information
136 collection procedure to be adopted and used by all insurers for
137 purposes of underwriting;

138 (16) Determine employer eligibility for a tax credit and the amount

139 of such tax credit in accordance with section 38 of this act and provide
140 certification for use in claiming such tax credit from the Department of
141 Revenue Services;

142 (17) Receive moneys from the Comptroller and make payments to
143 eligible individuals and employers in accordance with sections 8 and 9
144 of this act; and

145 (18) Not later than July 1, 2009, and annually thereafter, provide
146 data and reports to the Health Care Reform Commission and the
147 General Assembly, which shall include, but not be limited to (A) the
148 number and demographics of previously uninsured persons covered
149 through the Connecticut Connector by type of policy, (B) the per capita
150 administrative costs of the Connecticut Connector, (C) any
151 recommendations for improving service, health insurance policy
152 offerings and costs, and (D) any other information as required by said
153 commission.

154 Sec. 4. (NEW) (*Effective March 1, 2009*) (a) The association that
155 administers the Connecticut Connector shall make available a choice of
156 three health insurance plan types as follows: (1) Affordable health care
157 plans established in accordance with standards established by the
158 Health Care Reform Commission established under section 2 of this
159 act; (2) comprehensive health care plans as may be offered by insurers
160 at the option of such insurers; and (3) health savings accounts plus
161 high deductible plans as may be offered by insurers at the option of
162 such insurers. Each plan offered shall be specifically priced for sale
163 through the Connecticut Connector to reflect the reduced
164 administrative costs to the insurer resulting from the performance of
165 administrative duties by said connector.

166 (b) The affordable health care plans shall be exempt from the
167 minimum coverages or benefits set forth in chapter 700c of the general
168 statutes. The premium for any such plans shall not exceed two
169 hundred dollars per member per month on average, adjusted for
170 inflation in average premiums in the state by a percentage determined

171 annually by the Insurance Department. Such plans shall have a
172 minimum loss ratio of not less than eighty-five per cent for employer
173 health care plans and not less than seventy-five per cent for individual
174 health care plans over any three-year moving average period. Any
175 plan that fails to meet such minimum loss ratio shall be required by
176 said department to lower its premium to an amount that results in
177 compliance with such minimum loss ratio. Such plans shall include,
178 but not be limited to:

179 (1) Coverage of physician, clinic, ambulatory surgery, laboratory
180 and diagnostic services, in-patient and out-patient hospital care and
181 prescription drugs that are medically necessary for physical or mental
182 health;

183 (2) Out-of-pocket costs including, but not limited to, copayments,
184 deductibles and coinsurance that shall reflect the following family
185 income brackets: (A) Family income that is less than two hundred per
186 cent of the federal poverty level; (B) family income that equals or
187 exceeds two hundred per cent of the federal poverty level but does not
188 exceed three hundred per cent of the federal poverty level; and (C)
189 family income that exceeds three hundred per cent of the federal
190 poverty level but does not exceed four hundred per cent of the federal
191 poverty level.

192 (3) No deductible for well-child visits, prenatal care and the first
193 two physician visits, except in the case of a high deductible health plan
194 as that term is used in subsection (f) of section 38a-520 of the general
195 statutes; and

196 (4) A lifetime benefits maximum in an amount not less than five
197 hundred thousand dollars, contingent upon the availability of an
198 excess cost reinsurance program through the Department of Social
199 Services for which an individual or family would become eligible
200 without spending down all of their resources upon exhaustion of their
201 insurance benefit. In the event such excess cost reinsurance program is
202 not available, the lifetime benefits maximum shall be in an amount not

203 less than one million dollars.

204 (c) The Connecticut Connector, with respect to an applicant for an
205 individual affordable health care plan with an identified preexisting
206 condition, has the option to deny coverage to such applicant or cede
207 risk for such identified preexisting condition to the Connecticut
208 Individual Health Reinsurance Pool established under section 6 of this
209 act for any costs relative to such condition in excess of five thousand
210 dollars but not in excess of seventy-five thousand dollars for the first
211 twelve months of the term of the individual affordable health care plan
212 offered under this section. Such amounts shall be annually indexed to
213 the consumer price index for medical care. Each individual affordable
214 health care plan offered through the Connecticut Connector:

215 (1) Shall have premium rates established on the basis of a
216 community rate, adjusted to reflect the individual's age, gender, not
217 more than two levels of health status, excellent and good, family
218 composition, county of residence and tobacco use;

219 (2) Shall be renewable at the option of the policyholder;

220 (3) May impose an exclusion for individuals who have a preexisting
221 condition in accordance with the provisions of section 38a-476 of the
222 general statutes; or

223 (4) May, for individuals who have a preexisting condition, impose
224 an additional deductible of not more than five hundred dollars for
225 such preexisting condition.

226 (d) Each employer health care plan offered through the Connecticut
227 Connector shall have premium rates established on the basis of a
228 community rate in accordance with the provisions of subdivision (5) of
229 section 38a-567 of the general statutes, except that administrative costs
230 specifically related to the Connecticut Connector shall be reflected in
231 such rates.

232 (e) Coverage under each of the health care plans shall be deemed to

233 be creditable coverage, as defined in 42 USC 300gg(c).

234 (f) Any employer that purchases coverage through the program
235 may offer its employees any or all of the plans described in subsection
236 (a) of this section. Such employer may offer the same percentage or
237 dollar contribution for all plans if such employer allows its employees
238 to select a plan.

239 Sec. 5. (NEW) (*Effective January 1, 2009*) (a) An application by an
240 individual, who can show proof of residency in the state, to purchase
241 coverage through the Connecticut Connector may be approved in
242 cases in which such individual has no access to employer-sponsored
243 coverage under which the employer pays a minimum of fifty per cent
244 of the cost of such coverage for an individual and their dependents
245 and such individual has been either:

246 (1) Uninsured for a period of at least six months; or

247 (2) Uninsured for a period of less than six months due to the
248 occurrence of a major life event that has resulted in such uninsured
249 status, including, but not limited to:

250 (A) Loss of coverage through the employer, due to termination of
251 employment;

252 (B) Death of, or abandonment by, a family member through whom
253 coverage was previously provided;

254 (C) Loss of dependent coverage when the individual's spouse
255 became Medicare eligible due to age or disability;

256 (D) Loss of coverage as a dependent under any group health
257 insurance policy providing coverage of the type specified in
258 subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 of the
259 general statutes due to age, divorce or other changes in status;

260 (E) Expiration of the coverage periods established by the
261 Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA)

262 (P.L. 99-272) as amended from time to time;

263 (F) Extreme economic hardship on the part of either the employee or
264 the employer, as determined by the organization that administers the
265 Connecticut Connector; and

266 (G) Any other events that may be specified by the Health Care
267 Reform Commission established under section 2 of this act.

268 (b) An application by an employer to purchase coverage through
269 the pool may be approved if such employer:

270 (1) Has fifty or fewer employees;

271 (2) Has not offered a comprehensive health insurance plan to any
272 employee for a period of at least six months;

273 (3) Will contribute a minimum of seventy per cent of the cost of the
274 least expensive plan available through the Connecticut Connector for
275 an employee and a minimum of fifty per cent of the cost of dependent
276 coverage under the least expensive plan available through the
277 Connecticut Connector for any dependent of such employee; and

278 (4) Assures that at least ninety per cent of its employees either have
279 coverage through another health care plan or will enroll in a health
280 care plan through the Connecticut Connector.

281 Sec. 6. (NEW) (*Effective March 1, 2009*) (a) (1) As used in this section:

282 (A) "Board" means the board of directors of the Connecticut Small
283 Employer Health Reinsurance Pool established under section 38a-569
284 of the general statutes;

285 (B) "Commissioner" means the Insurance Commissioner;

286 (C) "Health care center" means health care center as defined in
287 section 38a-175 of the general statutes;

288 (D) "Individual" means a natural person provided coverage under

289 an individual health insurance policy who is deemed to be the
290 policyholder;

291 (E) "Insurer" means any insurance company, hospital service
292 corporation, medical service corporation or health care center,
293 authorized to transact health insurance business in this state;

294 (F) "Member" means each insurer participating in the pool;

295 (G) "Plan of operation" means the plan of operation of the pool,
296 including articles, bylaws and operating rules, adopted by the board
297 pursuant to subdivision (3) of this subsection; and

298 (H) "Pool" means the Connecticut Individual Health Reinsurance
299 Pool established under subdivision (2) of this subsection.

300 (2) There is established a nonprofit entity to be known as the
301 "Connecticut Individual Health Reinsurance Pool". All insurers issuing
302 health insurance in this state on and after March 1, 2009, shall be
303 members of the pool. The board of directors of the Connecticut Small
304 Employer Health Reinsurance Pool established under section 38a-569
305 of the general statutes shall administer the pool.

306 (3) Within ninety days after the effective date of this section, the
307 board shall submit to the commissioner a plan of operation and
308 thereafter any amendments thereto necessary or suitable to assure the
309 fair, reasonable and equitable administration of the pool. The
310 commissioner shall, after notice and hearing, approve the plan of
311 operation provided the commissioner determines it to be suitable to
312 assure the fair, reasonable and equitable administration of the pool,
313 and provides for the sharing of pool gains or losses on an equitable
314 proportionate basis in accordance with the provisions of subsection (d)
315 of this section. The plan of operation shall become effective upon
316 approval in writing by the commissioner consistent with the date on
317 which the coverage under this section shall be made available. If the
318 board fails to submit a suitable plan of operation within one hundred
319 eighty days after the effective date of this section, or at any time

320 thereafter fails to submit suitable amendments to the plan of operation,
321 the commissioner shall, after notice and hearing, adopt and
322 promulgate a plan of operation or amendments, as appropriate. The
323 commissioner shall amend any plan adopted, as necessary, at the time
324 a plan of operation is submitted by the board and approved by the
325 commissioner.

326 (4) The plan of operation shall establish procedures for: (A)
327 Handling and accounting of assets and moneys of the pool, and for an
328 annual fiscal reporting to the commissioner; (B) selecting an
329 administering insurer and setting forth the powers and duties of the
330 administering insurer; (C) reinsuring risks in accordance with the
331 provisions of this section; (D) collecting assessments from all members
332 to provide for claims reinsured by the pool and for administrative
333 expenses incurred or estimated to be incurred during the period for
334 which the assessment is made; and (E) any additional matters at the
335 discretion of the board.

336 (5) The pool shall have the general powers and authority granted
337 under the laws of Connecticut to insurance companies licensed to
338 transact health insurance and, in addition thereto, the specific
339 authority to: (A) Enter into contracts as are necessary or proper to
340 carry out the provisions and purposes of this section, including the
341 authority, with the approval of the commissioner, to enter into
342 contracts with programs of other states for the joint performance of
343 common functions, or with persons or other organizations for the
344 performance of administrative functions; (B) sue or be sued, including
345 taking any legal actions necessary or proper for recovery of any
346 assessments for, on behalf of, or against members; (C) take such legal
347 action as necessary to avoid the payment of improper claims against
348 the pool; (D) define the array of health coverage products for which
349 reinsurance will be provided, and to issue reinsurance policies, in
350 accordance with the requirements of this section; (E) establish rules,
351 conditions and procedures pertaining to the reinsurance of members'
352 risks by the pool; (F) establish appropriate rates, rate schedules, rate
353 adjustments, rate classifications and any other actuarial functions

354 appropriate to the operation of the pool; (G) assess members in
355 accordance with the provisions of subsection (e) of this section, and to
356 make advance interim assessments as may be reasonable and
357 necessary for organizational and interim operating expenses. Any such
358 interim assessments shall be credited as offsets against any regular
359 assessments due following the close of the fiscal year; (H) appoint from
360 among members appropriate legal, actuarial and other committees as
361 necessary to provide technical assistance in the operation of the pool,
362 policy and other contract design, and any other function within the
363 authority of the pool; and (I) borrow money to effect the purposes of
364 the pool. Any notes or other evidence of indebtedness of the pool not
365 in default shall be legal investments for insurers and may be carried as
366 admitted assets.

367 (b) Any member may reinsure with the pool coverage of an
368 individual who has an identified preexisting condition for any costs
369 relative to such condition in excess of five thousand dollars but not in
370 excess of seventy-five thousand dollars for the first twelve months of
371 the term of the individual affordable health care plan offered under
372 section 4 of this act. Such amounts shall be annually indexed to the
373 consumer price index for medical care. Any reinsurance placed with
374 the pool from the date of the establishment of the pool regarding such
375 coverage shall be as provided by the commissioner in regulations
376 adopted in accordance with chapter 54 of the general statutes.

377 (c) Except as provided in subsection (d) of this section, premium
378 rates charged for reinsurance by the pool shall be established by the
379 pool, in accordance with regulations adopted by the commissioner
380 pursuant to chapter 54 of the general statutes.

381 (d) Premium rates charged for reinsurance by the pool to a health
382 care center licensed pursuant to chapter 698a of the general statutes
383 and subject to requirements that limit the amount of risk that may be
384 ceded to the pool, may be modified by the board, if appropriate, to
385 reflect the portion of risk that may be ceded to the pool.

386 (e) Subject to subsection (c) of this section, (1) following the close of
387 each fiscal year, the administering insurer shall determine the net
388 premiums, the pool expenses of administration and the incurred losses
389 for the year, taking into account investment income and other
390 appropriate gains and losses. Health insurance premiums and benefits
391 paid by a member that are less than an amount determined by the
392 board to justify the cost of collection shall not be considered for
393 purposes of determining assessments. For purposes of this subsection,
394 "net premiums" means health insurance premiums, less administrative
395 expense allowances.

396 (2) Any net loss for the year shall be recouped by assessments of
397 members. (A) Assessments shall first be apportioned by the board
398 among all members in proportion to their respective shares of the total
399 health insurance premiums earned in this state from health insurance
400 plans covering individuals during the calendar year coinciding with or
401 ending during the fiscal year of the pool, or on any other equitable
402 basis reflecting coverage of individuals as may be provided in the plan
403 of operations. An assessment shall be made pursuant to this
404 subparagraph against a health care center, which is approved by the
405 Secretary of Health and Human Services as a health maintenance
406 organization pursuant to 42 USC 300e et seq., subject to an assessment
407 adjustment formula adopted by the board and approved by the
408 commissioner for such health care centers which recognizes the
409 restrictions imposed on such health care centers by federal law. Such
410 adjustment formula shall be adopted by the board and approved by
411 the commissioner prior to the first anniversary of the pool's operation.
412 (B) If such net loss is not recouped before assessments totaling five per
413 cent of such premiums from plans and arrangements covering eligible
414 individuals have been collected, additional assessments shall be
415 apportioned by the board among all members in proportion to their
416 respective shares of the total health insurance premiums earned in this
417 state from other individual and group plans and arrangements,
418 exclusive of any individual Medicare supplement policies as defined in
419 section 38a-495 of the general statutes during such calendar year. (C)

420 Notwithstanding the provisions of this subdivision, the assessments to
421 any one member under subparagraph (A) or (B) of this subdivision
422 shall not exceed forty per cent of the total assessment under each
423 subparagraph for the first fiscal year of the pool's operation and fifty
424 per cent of the total assessment under each subparagraph for the
425 second fiscal year. Any amounts abated pursuant to this subparagraph
426 shall be assessed against the other members in a manner consistent
427 with the basis for assessments set forth in this subdivision.

428 (3) If assessments exceed actual losses and administrative expenses
429 of the pool, the excess shall be held at interest and used by the board to
430 offset future losses or to reduce pool premiums. As used in this
431 subsection, "future losses" includes reserves for incurred but not
432 reported claims.

433 (4) Each member's proportion of participation in the pool shall be
434 determined annually by the board based on annual statements and
435 other reports deemed necessary by the board and filed by the member
436 with it.

437 (5) Provision shall be made in the plan of operation for the
438 imposition of an interest penalty for late payment of assessments.

439 (6) The board may defer, in whole or in part, the assessment of a
440 health care center if, in the opinion of the board: (A) Payment of the
441 assessment would endanger the ability of the health care center to
442 fulfill its contractual obligations, or (B) in accordance with standards
443 included in the plan of operation, the health care center has written,
444 and reinsured in their entirety, a disproportionate number of
445 individual health care plans offered under section 4 of this act. In the
446 event an assessment against a health care center is deferred in whole or
447 in part, the amount by which such assessment is deferred may be
448 assessed against the other members in a manner consistent with the
449 basis for assessments set forth in this subsection. The health care center
450 receiving such deferment shall remain liable to the pool for the amount
451 deferred. The board may attach appropriate conditions to any such

452 deferment.

453 (f) (1) Neither the participation in the pool as members, the
454 establishment of rates, forms or procedures nor any other joint or
455 collective action required by this section shall be the basis of any legal
456 action, criminal or civil liability or penalty against the pool or any of its
457 members.

458 (2) Any person or member made a party to any action, suit, or
459 proceeding because the person or member served on the board or on a
460 committee or was an officer or employee of the pool shall be held
461 harmless and be indemnified against all liability and costs, including
462 the amounts of judgments, settlements, fines or penalties, and
463 expenses and reasonable attorney's fees incurred in connection with
464 the action, suit or proceeding. The indemnification shall not be
465 provided on any matter in which the person or member is finally
466 adjudged in the action, suit or proceeding to have committed a breach
467 of duty involving gross negligence, dishonesty, wilful misfeasance or
468 reckless disregard of the responsibilities of office. Costs and expenses
469 of the indemnification shall be prorated and paid for by all members.
470 The commissioner may retain actuarial consultants necessary to carry
471 out his or her responsibilities pursuant to this section, and such
472 expenses shall be paid by the pool established in this section.

473 Sec. 7. (NEW) (*Effective October 1, 2007*) (a) The Connecticut
474 Connector as administered pursuant to section 3 of this act shall, not
475 later than thirty days after receipt of all relevant information provided
476 by an employer, determine whether to certify that an employer is
477 eligible for a tax credit pursuant to section 38 of this act.

478 (b) The Connecticut Connector shall provide information to
479 employers seeking assistance with obtaining certification pursuant to
480 this section.

481 Sec. 8. (NEW) (*Effective October 1, 2008*) (a) There is established the
482 health savings account incentive program. To be eligible for payment
483 pursuant to this section, an individual's family income may not exceed

484 three hundred per cent of the federal poverty level. The Connecticut
485 Connector shall annually contribute to the health savings account of
486 any individual who has resided in the state for a period of not less than
487 six months and who has a health savings account and high deductible
488 health plan pursuant to section 223 of the Internal Revenue Code of
489 1986, or any subsequent corresponding internal revenue code of the
490 United States, as from time to time amended, an amount determined
491 by a sliding scale as follows:

492 (1) For a family income equal to or less than two hundred per cent
493 of the federal poverty level, five hundred dollars for an individual who
494 has contributed or received contributions of at least two thousand five
495 hundred dollars in his or her health savings account in the previous
496 year, one thousand dollars for a family of two who has contributed or
497 received contributions of at least three thousand seven hundred fifty
498 dollars in their health savings account in the previous year, or one
499 thousand five hundred dollars for a family of three or more who has
500 contributed or received contributions of at least five thousand dollars
501 in their health savings account in the previous year.

502 (2) For a family income greater than two hundred per cent but less
503 than three hundred per cent of the federal poverty level, four hundred
504 dollars for an individual who has contributed or received
505 contributions of at least two thousand five hundred dollars in his or
506 her health savings account in the previous year, eight hundred dollars
507 for a family of two who has contributed or received contributions of at
508 least three thousand seven hundred fifty dollars in their health savings
509 account in the previous year, or one thousand two hundred dollars for
510 a family of three or more who has contributed or received
511 contributions of at least five thousand dollars in their health savings
512 account in the previous year.

513 (b) The amounts specified in subdivisions (1) and (2) of subsection
514 (a) of this section shall be annually indexed to the consumer price
515 index for medical care.

516 (c) Notwithstanding the provisions of subsection (a) of this section,
517 the Connecticut Connector shall not make contributions to the health
518 savings account of any individual if the total amount in such account
519 exceeds the deductible amount in the high deductible health plan. The
520 Connecticut Connector shall make contributions to a health savings
521 account up to a maximum amount equal to three times the deductible
522 amount in the high deductible health plan.

523 (d) The Connecticut Connector shall make payments, in accordance
524 with this section, by January thirtieth of any year for health savings
525 account contributions in the prior calendar year. The Connecticut
526 Connector shall establish procedures by which individuals may claim
527 payment pursuant to this section.

528 Sec. 9. (NEW) (*Effective October 1, 2008*) (a) There is established the
529 premium subsidy program. To be eligible for payment pursuant to this
530 section, an individual (1) shall not have family income exceeding three
531 hundred per cent of the federal poverty level, (2) shall not individually
532 or as part of a family own a health savings account pursuant to section
533 223 of the Internal Revenue Code of 1986, or any subsequent
534 corresponding internal revenue code of the United States, as from time
535 to time amended, and (3) shall have an affordable health care plan
536 purchased through the Connecticut Connector or any group health
537 insurance policy providing coverage of the type specified in
538 subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 of the
539 general statutes for which the employee pays at least five hundred
540 dollars in premiums annually to the employee's employer if single and
541 at least one thousand dollars in premiums annually to the employee's
542 employer if the employee is covered by a family plan or under a
543 nonemployer-based plan purchased through the individual market or
544 the Connecticut Connector. The Connecticut Connector shall quarterly
545 reimburse an individual who is eligible pursuant to this section for
546 premiums paid in the preceding quarter an average amount as follows:

547 (A) For a family with income equal to or less than two hundred per
548 cent of the federal poverty level, eighty per cent of the individual

549 premium or of their share of the premium for an employer-sponsored
550 plan, not to exceed three hundred dollars per quarter for an individual,
551 six hundred dollars per quarter for an individual plus one dependent,
552 or nine hundred dollars per quarter for a family.

553 (B) For a family with income greater than two hundred per cent but
554 less than three hundred per cent of the federal poverty level, sixty per
555 cent of the individual premium or of their share of the premium for an
556 employer-sponsored plan, not to exceed one hundred fifty dollars per
557 quarter for an individual, three hundred dollars per quarter for an
558 individual plus one dependent, or four hundred fifty dollars per
559 quarter for a family.

560 (b) The amounts specified in subparagraphs (A) and (B) of
561 subdivision (3) of subsection (a) of this section shall be adjusted in the
562 case of an individual seeking payment for the purchase of an
563 individual insurance plan based on the age, gender and county of
564 residence of the individual and calculated by the Connecticut
565 Connector to reflect the differences in premiums applied to each rating
566 classification.

567 (c) The amounts specified in subparagraphs (A) and (B) of
568 subdivision (3) of subsection (a) of this section shall be increased by
569 twenty per cent for any individual purchasing health care coverage
570 through the Health Reinsurance Association.

571 (d) The Connecticut Connector shall establish procedures by which
572 individuals may claim payment pursuant to this section.

573 Sec. 10. Section 38a-567 of the general statutes is repealed and the
574 following is substituted in lieu thereof (*Effective January 1, 2008*):

575 Health insurance plans and insurance arrangements covering small
576 employers and insurers and producers marketing such plans and
577 arrangements shall be subject to the following provisions:

578 (1) (A) Any such plan or arrangement shall be renewable with

579 respect to all eligible employees or dependents at the option of the
580 small employer, policyholder or contract-holder, as the case may be,
581 except: (i) For nonpayment of the required premiums by the small
582 employer, policyholder or contract-holder; (ii) for fraud or
583 misrepresentation of the small employer, policyholder or
584 contractholder or, with respect to coverage of individual insured, the
585 insureds or their representatives; (iii) for noncompliance with plan or
586 arrangement provisions; (iv) when the number of insureds covered
587 under the plan or arrangement is less than the number of insureds or
588 percentage of insureds required by participation requirements under
589 the plan or arrangement; or (v) when the small employer, policyholder
590 or contractholder is no longer actively engaged in the business in
591 which it was engaged on the effective date of the plan or arrangement.

592 (B) Renewability of coverage may be effected by either continuing in
593 effect a plan or arrangement covering a small employer or by
594 substituting upon renewal for the prior plan or arrangement the plan
595 or arrangement then offered by the carrier that most closely
596 corresponds to the prior plan or arrangement and is available to other
597 small employers. Such substitution shall only be made under
598 conditions approved by the commissioner. A carrier may substitute a
599 plan or arrangement as stated above only if the carrier effects the same
600 substitution upon renewal for all small employers previously covered
601 under the particular plan or arrangement, unless otherwise approved
602 by the commissioner. The substitute plan or arrangement shall be
603 subject to the rating restrictions specified in this section on the same
604 basis as if no substitution had occurred, except for an adjustment
605 based on coverage differences.

606 (C) Notwithstanding the provisions of this subdivision, any such
607 plan or arrangement, or any coverage provided under such plan or
608 arrangement may be rescinded for fraud, material misrepresentation
609 or concealment by an applicant, employee, dependent or small
610 employer.

611 (D) Any individual who was not a late enrollee at the time of his or

612 her enrollment and whose coverage is subsequently rescinded shall be
613 allowed to reenroll as of a current date in such plan or arrangement
614 subject to any preexisting condition or other provisions applicable to
615 new enrollees without previous coverage. On and after the effective
616 date of such individual's reenrollment, the small employer carrier may
617 modify the premium rates charged to the small employer for the
618 balance of the current rating period and for future rating periods, to
619 the level determined by the carrier as applicable under the carrier's
620 established rating practices had full, accurate and timely underwriting
621 information been supplied when such individual initially enrolled in
622 the plan. The increase in premium rates allowed by this provision for
623 the balance of the current rating period shall not exceed twenty-five
624 per cent of the small employer's current premium rates. Any such
625 increase for the balance of said current rating period shall not be
626 subject to the rate limitation specified in subdivision (6) of this section.
627 The rate limitation specified in this section shall otherwise be fully
628 applicable for the current and future rating periods. The modification
629 of premium rates allowed by this subdivision shall cease to be
630 permitted for all plans and arrangements on the first rating period
631 commencing on or after July 1, 1995.

632 (2) Except in the case of a late enrollee who has failed to provide
633 evidence of insurability satisfactory to the insurer, the plan or
634 arrangement may not exclude any eligible employee or dependent
635 who would otherwise be covered under such plan or arrangement on
636 the basis of an actual or expected health condition of such person. No
637 plan or arrangement may exclude an eligible employee or eligible
638 dependent who, on the day prior to the initial effective date of the plan
639 or arrangement, was covered under the small employer's prior health
640 insurance plan or arrangement pursuant to workers' compensation,
641 continuation of benefits pursuant to federal extension requirements
642 established by the Consolidated Omnibus Budget Reconciliation Act of
643 1985 (P.L. 99-2721, as amended) or other applicable laws. The
644 employee or dependent must request coverage under the new plan or
645 arrangement on a timely basis and such coverage shall terminate in

646 accordance with the provisions of the applicable law.

647 (3) (A) For rating periods commencing on or after October 1, 1993,
648 and prior to July 1, 1994, the premium rates charged or offered for a
649 rating period for all plans and arrangements may not exceed one
650 hundred thirty-five per cent of the base premium rate for all plans or
651 arrangements.

652 (B) For rating periods commencing on or after July 1, 1994, and prior
653 to July 1, 1995, the premium rates charged or offered for a rating
654 period for all plans or arrangements may not exceed one hundred
655 twenty per cent of the base premium rate for such rating period. The
656 provisions of this subdivision shall not apply to any small employer
657 who employs more than twenty-five eligible employees.

658 (4) For rating periods commencing on or after October 1, 1993, and
659 prior to July 1, 1995, the percentage increase in the premium rate
660 charged to a small employer, who employs not more than twenty-five
661 eligible employees, for a new rating period may not exceed the sum of:

662 (A) The percentage change in the base premium rate measured from
663 the first day of the prior rating period to the first day of the new rating
664 period;

665 (B) An adjustment of the small employer's premium rates for the
666 prior rating period, and adjusted pro rata for rating periods of less
667 than one year, due to the claim experience, health status or duration of
668 coverage of the employees or dependents of the small employer, such
669 adjustment (i) not to exceed ten per cent annually for the rating
670 periods commencing on or after October 1, 1993, and prior to July 1,
671 1994, and (ii) not to exceed five per cent annually for the rating periods
672 commencing on or after July 1, 1994, and prior to July 1, 1995; and

673 (C) Any adjustments due to change in coverage or change in the
674 case characteristics of the small employer, as determined from the
675 small employer carrier's applicable rate manual.

676 (5) (A) With respect to plans or arrangements delivered, issued for
677 delivery, renewed, amended or continued in this state on or after July
678 1, [1995] 2008, the premium rates charged or offered to small
679 employers shall be established on the basis of a community rate,
680 adjusted to reflect one or more of the following classifications:

681 (i) Age, provided age brackets of less than five years shall not be
682 utilized;

683 (ii) Gender;

684 (iii) Geographic area, provided an area smaller than a county shall
685 not be utilized;

686 (iv) Industry, provided the rate factor associated with any industry
687 classification shall not vary from the arithmetic average of the highest
688 and lowest rate factors associated with all industry classifications by
689 greater than fifteen per cent of such average, and provided further, the
690 rate factors associated with any industry shall not be increased by
691 more than five per cent per year;

692 (v) Group size, provided the highest rate factor associated with
693 group size shall not vary from the lowest rate factor associated with
694 group size by a ratio of greater than 1.25 to 1.0;

695 (vi) Administrative cost savings resulting from the administration of
696 an association group plan or a plan written pursuant to section 5-259,
697 provided the savings reflect a reduction to the small employer carrier's
698 overall retention that is measurable and specifically realized on items
699 such as marketing, billing or claims paying functions taken on directly
700 by the plan administrator or association, except that such savings may
701 not reflect a reduction realized on commissions;

702 (vii) Savings resulting from a reduction in the profit of a carrier who
703 writes small business plans or arrangements for an association group
704 plan or a plan written pursuant to section 5-259 provided any loss in
705 overall revenue due to a reduction in profit is not shifted to other small

706 employers; [and]

707 (viii) Family composition, provided the small employer carrier shall
708 utilize only one or more of the following billing classifications: (I)
709 Employee; (II) employee plus family; (III) employee and spouse; (IV)
710 employee and child; (V) employee plus one dependent; and (VI)
711 employee plus two or more dependents; and

712 (ix) Compliance with or participation in a program of health-
713 enhancing behavior associated with avoidance of tobacco use.

714 (B) The small employer carrier shall quote premium rates to small
715 employers after receipt of all demographic rating classifications of the
716 small employer group. No small employer carrier may inquire
717 regarding health status or claims experience of the small employer or
718 its employees or dependents prior to the quoting of a premium rate.

719 (C) The provisions of subparagraphs (A) and (B) of this subdivision
720 shall apply to plans or arrangements issued on or after July 1, 1995.
721 The provisions of subparagraphs (A) and (B) of this subdivision shall
722 apply to plans or arrangements issued prior to July 1, 1995, as of the
723 date of the first rating period commencing on or after that date, but no
724 later than July 1, 1996.

725 (6) For any small employer plan or arrangement on which the
726 premium rates for employee and dependent coverage or both, vary
727 among employees, such variations shall be based solely on age and
728 other demographic factors permitted under subparagraph (A) of
729 subdivision (5) of this section and such variations may not be based on
730 health status, claim experience, or duration of coverage of specific
731 enrollees. Except as otherwise provided in subdivision (1) of this
732 section, any adjustment in premium rates charged for a small
733 employer plan or arrangement to reflect changes in case characteristics
734 prior to the end of a rating period shall not include any adjustment to
735 reflect the health status, medical history or medical underwriting
736 classification of any new enrollee for whom coverage begins during
737 the rating period.

738 (7) For rating periods commencing prior to July 1, 1995, in any case
739 where a small employer carrier utilized industry classification as a case
740 characteristic in establishing premium rates, the rate factor associated
741 with any industry classification shall not vary from the arithmetical
742 average of the highest and lowest rate factors associated with all
743 industry classifications by greater than fifteen per cent of such average.

744 (8) Differences in base premium rates charged for health benefit
745 plans by a small employer carrier shall be reasonable and reflect
746 objective differences in plan design, not including differences due to
747 the nature of the groups assumed to select particular health benefit
748 plans.

749 (9) For rating periods commencing prior to July 1, 1995, in any case
750 where an insurer issues or offers a policy or contract under which
751 premium rates for a specific small employer are established or
752 adjusted in part based upon the actual or expected variation in claim
753 costs or actual or expected variation in health conditions of the
754 employees or dependents of such small employer, the insurer shall
755 make reasonable disclosure of such rating practices in solicitation and
756 sales materials utilized with respect to such policy or contract.

757 (10) If a small employer carrier denies coverage to a small employer,
758 the small employer carrier shall promptly offer the small employer the
759 opportunity to purchase a special health care plan or a small employer
760 health care plan, as appropriate. If a small employer carrier or any
761 producer representing that carrier fails, for any reason, to offer such
762 coverage as requested by a small employer, that small employer carrier
763 shall promptly offer the small employer an opportunity to purchase a
764 special health care plan or a small employer health care plan, as
765 appropriate.

766 (11) No small employer carrier or producer shall, directly or
767 indirectly, engage in the following activities:

768 (A) Encouraging or directing small employers to refrain from filing
769 an application for coverage with the small employer carrier because of

770 the health status, claims experience, industry, occupation or
771 geographic location of the small employer, except the provisions of
772 this subparagraph shall not apply to information provided by a small
773 employer carrier or producer to a small employer regarding the
774 carrier's established geographic service area or a restricted network
775 provision of a small employer carrier; or

776 (B) Encouraging or directing small employers to seek coverage from
777 another carrier because of the health status, claims experience,
778 industry, occupation or geographic location of the small employer.

779 (12) No small employer carrier shall, directly or indirectly, enter into
780 any contract, agreement or arrangement with a producer that provides
781 for or results in the compensation paid to a producer for the sale of a
782 health benefit plan to be varied because of the health status, claims
783 experience, industry, occupation or geographic area of the small
784 employer. A small employer carrier shall provide reasonable
785 compensation, as provided under the plan of operation of the
786 program, to a producer, if any, for the sale of a special or a small
787 employer health care plan. No small employer carrier shall terminate,
788 fail to renew or limit its contract or agreement of representation with a
789 producer for any reason related to the health status, claims experience,
790 occupation, or geographic location of the small employers placed by
791 the producer with the small employer carrier.

792 (13) No small employer carrier or producer shall induce or
793 otherwise encourage a small employer to separate or otherwise
794 exclude an employee from health coverage or benefits provided in
795 connection with the employee's employment.

796 (14) Denial by a small employer carrier of an application for
797 coverage from a small employer shall be in writing and shall state the
798 reasons for the denial.

799 (15) No small employer carrier or producer shall disclose (A) to a
800 small employer the fact that any or all of the eligible employees of such
801 small employer have been or will be reinsured with the pool, or (B) to

802 any eligible employee or dependent the fact that he has been or will be
803 reinsured with the pool.

804 (16) If a small employer carrier enters into a contract, agreement or
805 other arrangement with another party to provide administrative,
806 marketing or other services related to the offering of health benefit
807 plans to small employers in this state, the other party shall be subject
808 to the provisions of this section.

809 (17) The commissioner may adopt regulations in accordance with
810 the provisions of chapter 54 setting forth additional standards to
811 provide for the fair marketing and broad availability of health benefit
812 plans to small employers.

813 (18) Each small employer carrier shall maintain at its principle place
814 of business a complete and detailed description of its rating practices
815 and renewal underwriting practices, including information and
816 documentation that demonstrates that its rating methods and practices
817 are based upon commonly accepted actuarial assumptions and are in
818 accordance with sound actuarial principles. Each small employer
819 carrier shall file with the commissioner annually, on or before March
820 fifteenth, an actuarial certification certifying that the carrier is in
821 compliance with this part and that the rating methods have been
822 derived using recognized actuarial principles consistent with the
823 provisions of sections 38a-564 to 38a-573, inclusive. Such certification
824 shall be in a form and manner and shall contain such information, as
825 determined by the commissioner. A copy of the certification shall be
826 retained by the small employer carrier at its principle place of business.
827 Any information and documentation described in this subdivision but
828 not subject to the filing requirement shall be made available to the
829 commissioner upon his request. Except in cases of violations of
830 sections 38a-564 to 38a-573, inclusive, the information shall be
831 considered proprietary and trade secret information and shall not be
832 subject to disclosure by the commissioner to persons outside of the
833 department except as agreed to by the small employer carrier or as
834 ordered by a court of competent jurisdiction.

835 (19) The commissioner may suspend all or any part of this section
836 relating to the premium rates applicable to one or more small
837 employers for one or more rating periods upon a filing by the small
838 employer carrier and a finding by the commissioner that either the
839 suspension is reasonable in light of the financial condition of the
840 carrier or that the suspension would enhance the efficiency and
841 fairness of the marketplace for small employer health insurance.

842 (20) For rating periods commencing prior to July 1, 1995, a small
843 employer carrier shall quote premium rates to any small employer
844 within thirty days after receipt by the carrier of such employer's
845 completed application.

846 (21) Any violation of subdivisions (10) to (16), inclusive, and any
847 regulations established under subdivision (17) of this section shall be
848 an unfair and prohibited practice under sections 38a-815 to 38a-830,
849 inclusive.

850 (22) With respect to plans or arrangements issued pursuant to
851 subsection (i) of section 5-259, or by an association group plan, at the
852 option of the Comptroller or the administrator of the association group
853 plan, the premium rates charged or offered to small employers
854 purchasing health insurance shall not be subject to this section,
855 provided (A) the plan or plans offered or issued cover such small
856 employers as a single entity and cover not less than ten thousand
857 eligible individuals on the date issued, (B) each small employer is
858 charged or offered the same premium rate with respect to each eligible
859 individual and dependent, and (C) the plan or plans are written on a
860 guaranteed issue basis.

861 Sec. 11. Section 38a-497 of the general statutes is repealed and the
862 following is substituted in lieu thereof (*Effective October 1, 2007*):

863 [Every] (a) Each individual health insurance policy providing
864 coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11)
865 and (12) of section 38a-469 delivered, issued for delivery, amended or
866 renewed in this state on or after [October 1, 1982] January 1, 2008, shall

867 provide that coverage of a child of the policyholder shall terminate no
868 earlier than the policy anniversary date on or after whichever of the
869 following occurs first, the date on which the child marries, [ceases to
870 be a dependent of the policyholder,] attains the age of nineteen if the
871 child is not a full-time or part-time student at an accredited institution,
872 or attains the age of twenty-three if the child is a full-time or part-time
873 student at an accredited institution.

874 (b) Each individual health insurance policy providing coverage of
875 the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of
876 section 38a-469 delivered, issued for delivery, amended or renewed in
877 this state on or after January 1, 2008, shall, at the option of the
878 policyholder, provide coverage of a child who is not covered under
879 subsection (a) of this section, provided the child is: (1) Under twenty-
880 five years of age, (2) unmarried, (3) a resident of this state or is enrolled
881 as a full-time or part-time student at an accredited institution, and (4)
882 not offered or provided coverage under a health benefits plan
883 sponsored or arranged by the child's own employer. The insurer,
884 health care center or other entity providing coverage under this
885 subsection may charge the policyholder an additional premium for
886 such coverage if the policyholder elects such coverage.

887 Sec. 12. (NEW) (*Effective October 1, 2007*) (a) Each group health
888 insurance policy providing coverage of the type specified in
889 subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 of the
890 general statutes delivered, issued for delivery, amended or renewed in
891 this state on or after January 1, 2008, shall provide that coverage of a
892 child of the insured shall terminate no earlier than the date on or after
893 whichever of the following occurs first, the date on which the child
894 marries, attains the age of nineteen if the child is not a full-time or part-
895 time student at an accredited institution or attains the age of twenty-
896 three if the child is a full-time or part-time student at an accredited
897 institution.

898 (b) Each group health insurance policy providing coverage of the
899 type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of

900 section 38a-469 of the general statutes delivered, issued for delivery,
901 amended or renewed in this state on or after January 1, 2008, shall, at
902 the option of the insured, provide coverage of a child who is not
903 covered under subsection (a) of this section, provided the child is: (1)
904 Under twenty-five years of age, (2) unmarried, (3) a resident of this
905 state or is enrolled as a full-time or part-time student at an accredited
906 institution, and (4) not offered or provided coverage under a health
907 benefits plan sponsored or arranged by the child's own employer. The
908 insurer, health care center or other entity providing coverage under
909 this subsection may charge the insured an additional premium for
910 such coverage if the insured elects such coverage.

911 (c) Each group health insurance policy providing coverage of the
912 type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of
913 section 38a-469 of the general statutes delivered, issued for delivery,
914 amended or renewed in this state on or after January 1, 2008, shall
915 provide the option to continue coverage under each of the following
916 circumstances until the individual is eligible for other group insurance,
917 except as provided in subdivisions (3) and (4) of this subsection: (1)
918 Notwithstanding any provision of this section, upon layoff, reduction
919 of hours, leave of absence, or termination of employment, other than as
920 a result of death of the employee or as a result of such employee's
921 "gross misconduct" as that term is used in 29 USC 1163(2), continuation
922 of coverage for such employee and such employee's covered
923 dependents for the periods set forth for such event under federal
924 extension requirements established by the federal Consolidated
925 Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended
926 from time to time, (COBRA), except that if such reduction of hours,
927 leave of absence or termination of employment results from an
928 employee's eligibility to receive Social Security income, continuation of
929 coverage for such employee and such employee's covered dependents
930 until midnight of the day preceding such person's eligibility for
931 benefits under Title XVIII of the Social Security Act; (2) upon the death
932 of the employee, continuation of coverage for the covered dependents
933 of such employee for the periods set forth for such event under federal

934 extension requirements established by the Consolidated Omnibus
935 Budget Reconciliation Act of 1985 (P.L. 99-272), as amended from time
936 to time, (COBRA); (3) regardless of the employee's or dependent's
937 eligibility for other group insurance, during an employee's absence
938 due to illness or injury, continuation of coverage for such employee
939 and such employee's covered dependents during continuance of such
940 illness or injury or for up to twelve months from the beginning of such
941 absence; (4) regardless of an individual's eligibility for other group
942 insurance, upon termination of the group policy, coverage for covered
943 individuals who were totally disabled on the date of termination shall
944 be continued without premium payment during the continuance of
945 such disability for a period of twelve calendar months following the
946 calendar month in which the policy was terminated, provided claim is
947 submitted for coverage within one year of the termination of the
948 policy; (5) the coverage of any covered individual shall terminate: (A)
949 As to a child, the policy shall provide the option for said child to
950 continue coverage for the longer of the following periods: (i) At the
951 end of the month following the month in which the child marries or
952 attains the age of nineteen if the child is not a full-time or part-time
953 student at an accredited institution or attains the age of twenty-three if
954 the child is a full-time or part-time student at an accredited institution
955 or attains the age of twenty-five if the child is a resident of this state or
956 enrolled as a full-time or part-time student at an accredited institution
957 and is not offered or provided coverage under a health benefits plan
958 sponsored or arranged by the child's own employer. If on the date
959 specified for termination of coverage on a child of the policyholder, the
960 child is unmarried and incapable of self-sustaining employment by
961 reason of mental or physical handicap and chiefly dependent upon the
962 employee for support and maintenance, the coverage on such child
963 shall continue while the policy remains in force and the child remains
964 in such condition, provided proof of such handicap is received by the
965 carrier within thirty-one days of the date on which the child's coverage
966 would have terminated in the absence of such incapacity. The carrier
967 may require subsequent proof of the child's continued incapacity and
968 dependency but not more often than once a year thereafter, or (ii) for

969 the periods set forth for such child under federal extension
970 requirements established by the Consolidated Omnibus Budget
971 Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time,
972 (COBRA); (B) as to the employee's spouse, at the end of the month
973 following the month in which a divorce, court-ordered annulment or
974 legal separation is obtained, whichever is earlier, except that the policy
975 shall provide the option for said spouse to continue coverage for the
976 periods set forth for such events under federal extension requirements
977 established by the Consolidated Omnibus Budget Reconciliation Act of
978 1985 (P.L. 99-272), as amended from time to time, (COBRA); and (C) as
979 to the employee or dependent who is sixty-five years of age or older,
980 as of midnight of the day preceding such person's eligibility for
981 benefits under Title XVIII of the federal Social Security Act; (6) as to
982 any other event listed as a "qualifying event" in 29 USC 1163, as
983 amended from time to time, continuation of coverage for such periods
984 set forth for such event in 29 USC 1162, as amended from time to time,
985 provided such policy may require the individual whose coverage is to
986 be continued to pay up to the percentage of the applicable premium as
987 specified for such event in 29 USC 1162, as amended from time to time.
988 Any continuation of coverage required by this section except
989 subdivision (4) or (6) of this subsection may be subject to the
990 requirement, on the part of the individual whose coverage is to be
991 continued, that such individual contribute that portion of the premium
992 the individual would have been required to contribute had the
993 employee remained an active covered employee, except that the
994 individual may be required to pay up to one hundred two per cent of
995 the entire premium at the group rate if coverage is continued in
996 accordance with subdivision (1), (2) or (5) of this subsection. The
997 employer shall not be legally obligated by sections 38a-505, 38a-546
998 and 38a-551 to 38a-559, inclusive, of the general statutes to pay such
999 premium if not paid timely by the employee. The policy shall make
1000 available to residents of this state, in addition to any other conversion
1001 privilege available, a conversion privilege under which coverage shall
1002 be available immediately upon termination of coverage under the
1003 group policy. The terms and benefits offered under the conversion

1004 benefits shall be at least equal to the terms and benefits of an
1005 individual comprehensive health care policy. For the purposes of this
1006 subsection, "dependent" means the spouse and children of an eligible
1007 employee.

1008 Sec. 13. Section 38a-554 of the general statutes is repealed and the
1009 following is substituted in lieu thereof (*Effective October 1, 2007*):

1010 A group comprehensive health care plan shall contain the minimum
1011 standard benefits prescribed in section 38a-553 and shall also conform
1012 in substance to the requirements of this section.

1013 (a) The plan shall be one under which the individuals eligible to be
1014 covered include: (1) Each eligible employee; (2) the spouse of each
1015 eligible employee; [, who shall be considered a dependent for the
1016 purposes of this section;] and (3) [dependent] unmarried children,
1017 [who are under the age of nineteen or are full-time students under the
1018 age of twenty-three at an accredited institution of higher learning] to
1019 the same extent as provided in subsections (a) and (b) of section 12 of
1020 this act.

1021 (b) The plan shall provide the option to continue coverage under
1022 [each of] the [following] circumstances [until the individual is eligible
1023 for other group insurance, except as provided in subdivisions (3) and
1024 (4) of this subsection: (1) Notwithstanding any provision of this
1025 section, upon layoff, reduction of hours, leave of absence, or
1026 termination of employment, other than as a result of death of the
1027 employee or as a result of such employee's "gross misconduct" as that
1028 term is used in 29 USC 1163(2), continuation of coverage for such
1029 employee and such employee's covered dependents for the periods set
1030 forth for such event under federal extension requirements established
1031 by the federal Consolidated Omnibus Budget Reconciliation Act of
1032 1985 (P.L. 99-272), as amended from time to time, (COBRA), except
1033 that if such reduction of hours, leave of absence or termination of
1034 employment results from an employee's eligibility to receive Social
1035 Security income, continuation of coverage for such employee and such

1036 employee's covered dependents until midnight of the day preceding
1037 such person's eligibility for benefits under Title XVIII of the Social
1038 Security Act; (2) upon the death of the employee, continuation of
1039 coverage for the covered dependents of such employee for the periods
1040 set forth for such event under federal extension requirements
1041 established by the Consolidated Omnibus Budget Reconciliation Act of
1042 1985 (P.L. 99-272), as amended from time to time, (COBRA); (3)
1043 regardless of the employee's or dependent's eligibility for other group
1044 insurance, during an employee's absence due to illness or injury,
1045 continuation of coverage for such employee and such employee's
1046 covered dependents during continuance of such illness or injury or for
1047 up to twelve months from the beginning of such absence; (4)
1048 regardless of an individual's eligibility for other group insurance, upon
1049 termination of the group plan, coverage for covered individuals who
1050 were totally disabled on the date of termination shall be continued
1051 without premium payment during the continuance of such disability
1052 for a period of twelve calendar months following the calendar month
1053 in which the plan was terminated, provided claim is submitted for
1054 coverage within one year of the termination of the plan; (5) the
1055 coverage of any covered individual shall terminate: (A) As to a child,
1056 the plan shall provide the option for said child to continue coverage for
1057 the longer of the following periods: (i) At the end of the month
1058 following the month in which the child marries, ceases to be
1059 dependent on the employee or attains the age of nineteen, whichever
1060 occurs first, except that if the child is a full-time student at an
1061 accredited institution, the coverage may be continued while the child
1062 remains unmarried and a full-time student, but not beyond the month
1063 following the month in which the child attains the age of twenty-three.
1064 If on the date specified for termination of coverage on a dependent
1065 child, the child is unmarried and incapable of self-sustaining
1066 employment by reason of mental or physical handicap and chiefly
1067 dependent upon the employee for support and maintenance, the
1068 coverage on such child shall continue while the plan remains in force
1069 and the child remains in such condition, provided proof of such
1070 handicap is received by the carrier within thirty-one days of the date

1071 on which the child's coverage would have terminated in the absence of
1072 such incapacity. The carrier may require subsequent proof of the
1073 child's continued incapacity and dependency but not more often than
1074 once a year thereafter, or (ii) for the periods set forth for such child
1075 under federal extension requirements established by the Consolidated
1076 Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended
1077 from time to time, (COBRA); (B) as to the employee's spouse, at the
1078 end of the month following the month in which a divorce, court-
1079 ordered annulment or legal separation is obtained, whichever is
1080 earlier, except that the plan shall provide the option for said spouse to
1081 continue coverage for the periods set forth for such events under
1082 federal extension requirements established by the Consolidated
1083 Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended
1084 from time to time, (COBRA); and (C) as to the employee or dependent
1085 who is sixty-five years of age or older, as of midnight of the day
1086 preceding such person's eligibility for benefits under Title XVIII of the
1087 federal Social Security Act; (6) as to any other event listed as a
1088 "qualifying event" in 29 USC 1163, as amended from time to time,
1089 continuation of coverage for such periods set forth for such event in 29
1090 USC 1162, as amended from time to time, provided such plan may
1091 require the individual whose coverage is to be continued to pay up to
1092 the percentage of the applicable premium as specified for such event in
1093 29 USC 1162, as amended from time to time. Any continuation of
1094 coverage required by this section except subdivision (4) or (6) of this
1095 subsection may be subject to the requirement, on the part of the
1096 individual whose coverage is to be continued, that such individual
1097 contribute that portion of the premium the individual would have
1098 been required to contribute had the employee remained an active
1099 covered employee, except that the individual may be required to pay
1100 up to one hundred two per cent of the entire premium at the group
1101 rate if coverage is continued in accordance with subdivision (1), (2) or
1102 (5) of this subsection. The employer shall not be legally obligated by
1103 sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, to pay such
1104 premium if not paid timely by the employee] specified in subsection
1105 (c) of section 12 of this act.

1106 (c) The commissioner shall adopt regulations, in accordance with
1107 chapter 54, concerning coordination of benefits between the plan and
1108 other health insurance plans.

1109 (d) The plan shall make available to Connecticut residents, in
1110 addition to any other conversion privilege available, a conversion
1111 privilege [under which coverage shall be available immediately upon
1112 termination of coverage under the group plan. The terms and benefits
1113 offered under the conversion benefits shall be at least equal to the
1114 terms and benefits of an individual comprehensive health care plan] as
1115 provided under subsection (c) of section 12 of this act.

1116 Sec. 14. Section 38a-482 of the general statutes is repealed and the
1117 following is substituted in lieu thereof (*Effective October 1, 2007*):

1118 No individual health insurance policy shall be delivered or issued
1119 for delivery to any person in this state unless: (1) The entire money and
1120 other considerations therefor are expressed therein; (2) the time at
1121 which the insurance takes effect and terminates is expressed therein;
1122 (3) such policy purports to insure only one person, except that a policy
1123 may insure, originally or by subsequent amendment, upon the
1124 application of an adult member of a family, who shall be deemed the
1125 policyholder, any two or more eligible members of such family,
1126 including husband, wife, dependent children or any children [under a
1127 specified age, which shall not exceed eighteen years] as specified in
1128 section 38a-497, as amended by this act, and any other person
1129 dependent upon the policyholder; (4) the style, arrangement and
1130 overall appearance of the policy give no undue prominence to any
1131 portion of the text, and every printed portion of the text of the policy
1132 and of any endorsements or attached papers is plainly printed in light-
1133 faced type of a style in general use, the size of which shall be uniform
1134 and not less than ten-point with a lowercase unspaced alphabet length
1135 not less than one hundred and twenty-point, the word "text" as herein
1136 used including all printed matter except the name and address of the
1137 insurer, name or title of the policy, the brief description, if any, and
1138 captions and subcaptions; (5) the exceptions and reductions of

1139 indemnity are set forth in the policy and, except as provided in section
1140 38a-483, are printed, at the insurer's option, either included with the
1141 benefit provision to which they apply, or under an appropriate caption
1142 such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS",
1143 provided, if an exception or reduction specifically applies only to a
1144 particular benefit of the policy, a statement of such exception or
1145 reduction shall be included with the benefit provision to which it
1146 applies; (6) each such form, including riders and endorsements, shall
1147 be identified by a form number in the lower left-hand corner of the
1148 first page thereof; and (7) such policy contains no provision purporting
1149 to make any portion of the charter, rules, constitution or bylaws of the
1150 insurer a part of the policy unless such portion is set forth in full in the
1151 policy, except in the case of the incorporation of, or reference to, a
1152 statement of rates or classification of risks, or short-rate table filed with
1153 the commissioner.

1154 Sec. 15. (*Effective July 1, 2007*) (a) The Commissioner of Health Care
1155 Access shall convene an electronic health information technology task
1156 force to develop and provide recommendations to the Governor on the
1157 impact of electronic health information exchange.

1158 (b) The task force shall be comprised of representatives from the
1159 public and private sectors and be selected by the Commissioner of
1160 Health Care Access. In appointing members to the task force, the
1161 commissioner shall consider the representative interests of (1)
1162 consumers; (2) providers, including, but not limited to, clinicians,
1163 pharmacists, health plans, hospitals, community-based health centers,
1164 federally qualified health centers, clinics, laboratories, pharmacies and
1165 professional societies or organizations; (3) public health entities; (4)
1166 academia; (5) employers; (6) health information exchange
1167 organizations; (7) state agencies including the Departments of Social
1168 Services, Public Health, Mental Retardation, Mental Health and
1169 Addiction Services, Children and Families, Veterans' Affairs,
1170 Information Technology, Consumer Protection, the Insurance
1171 Department, The University of Connecticut Health Center, the Office
1172 of Policy and Management and the Office of the State Comptroller; and

1173 (8) municipalities. The Commissioner of Health Care Access shall serve
1174 as the chairperson of the task force.

1175 (c) The task force shall: (1) Research and examine the impact of the
1176 electronic use of health information to improve the quality and
1177 efficiency of health information exchange; (2) inventory the various
1178 public and private health information technology initiatives currently
1179 underway in this state, including efforts regarding personal health
1180 records, electronic health records, computerized physician order entry
1181 in hospitals, electronic prescriptions and health information exchange;
1182 (3) identify the appropriate role of state government in the
1183 development, use and regulation of health information technology and
1184 define the goals and values of health information technology for the
1185 purposes of state policy and planning; (4) assess the impact of health
1186 information on the state's roles as payor, provider, purchaser,
1187 regulator and employer and recommend statutory, regulatory and
1188 policy changes including changes required to address privacy,
1189 confidentiality and public safety; (5) develop an overall state health
1190 information technology policy; (6) develop options for advancing the
1191 implementation of health information technology through the state's
1192 roles as payor, provider, purchaser, regulator and employer and
1193 identify opportunities and strategies for public and private
1194 collaboration; and (7) develop policy options for advancing the
1195 implementation of health information technology including projected
1196 costs and sources of funding.

1197 (d) Not later than September 1, 2008, the Commissioner of Health
1198 Care Access shall report to the Governor and the General Assembly, in
1199 accordance with section 11-4a of the general statutes, on the findings
1200 and recommendations of the task force. The electronic health
1201 information technology task force shall terminate upon the submission
1202 of the report.

1203 Sec. 16. (NEW) (*Effective July 1, 2007*) (a) On or before July 1, 2009,
1204 the Department of Public Health shall establish sufficient primary care
1205 clinics to supplement other primary care resources so that all state

1206 residents shall have ready access to necessary primary care. Such
1207 primary care clinics shall be licensed by the department pursuant to
1208 chapter 368v of the general statutes and provide physical and
1209 behavioral health care, including dental care, with appropriate
1210 linkages to other services in the state, including, but not limited to,
1211 specialty care providers, other primary care providers and pharmacies.
1212 Each primary care clinic shall be, or be operated by, a federally
1213 qualified health center, a health center determined by the
1214 Commissioner of Public Health to be substantially similar to a
1215 federally qualified health center or a hospital. Each primary care clinic
1216 shall provide a wide range of primary care services and shall remain
1217 open outside of normal business hours to provide access to urgent but
1218 nonemergency care.

1219 (b) The Department of Public Health shall establish and offer
1220 incentives for physicians and other health care providers who provide
1221 their services for a minimum number of hours to primary care clinics
1222 at a reduced rate. Such incentives may include, but need not be limited
1223 to, reduced cost medical malpractice insurance offered or arranged for
1224 by the department, loan forgiveness from postsecondary educational
1225 institutions that receive funding from the state and partial payment of
1226 educational loans.

1227 Sec. 17. (NEW) (*Effective July 1, 2007*) Not later than January 1, 2007,
1228 the Department of Public Health shall establish a Smoke-Free
1229 Connecticut program. The department shall contract with one or more
1230 entities to implement the program, which shall (1) promote smoking
1231 cessation among unserved or underserved populations, (2) educate the
1232 public regarding health complications related to smoking, (3) educate
1233 the public regarding smoking cessation methods, (4) provide or
1234 reimburse for medications, devices or other supplies to assist or
1235 support smoking cessation, (5) provide counseling and referral
1236 services for treatment, and (6) establish a system to track and monitor
1237 all individuals receiving smoking cessation assistance in the program.
1238 For purposes of this section, "unserved or underserved populations"
1239 means individuals who are at or below two hundred per cent of the

1240 federal poverty level and without health insurance that provides
1241 coverage for smoking cessation.

1242 Sec. 18. (NEW) (*Effective January 1, 2008*) (a) The Health Care Reform
1243 Commission, established under section 2 of this act, shall establish a
1244 subcommittee on Healthy Lifestyles. The subcommittee shall: (1) By
1245 March 1, 2008, develop a marketing campaign to educate the public
1246 regarding consequences of poor health and basic measures individuals
1247 should take to ensure good health; and (2) make recommendations to
1248 the General Assembly concerning incentives to encourage personal
1249 responsibility in making healthy lifestyle choices.

1250 (b) The subcommittee shall meet at least quarterly each year. The
1251 Health Care Reform Commission, within available appropriations,
1252 may hire consultants to provide assistance to the subcommittee with
1253 its responsibilities.

1254 (c) The Office of Health Care Access shall, within available
1255 appropriations, contract with one or more entities to implement the
1256 marketing campaign recommended by the subcommittee on Healthy
1257 Lifestyles.

1258 Sec. 19. (NEW) (*Effective July 1, 2007*) (a) Not later than July 1, 2008,
1259 the Health Care Reform Commission, established under section 2 of
1260 this act, shall establish the Connecticut Health Quality Partnership.
1261 The partnership may be composed of representatives from both the
1262 private and public sectors, including, but not limited to, health
1263 insurers, hospital associations, a representative of physicians, the
1264 Commissioners of Public Health and Social Services, representatives of
1265 Medicaid managed care organizations and not more than two
1266 consumer advocates who are not otherwise affiliated with any other
1267 members. The Health Care Reform Commission shall assign staff to
1268 assist the partnership with its responsibilities.

1269 (b) The Connecticut Health Quality Partnership shall: (1) Be
1270 responsible for collecting and analyzing insurance and Medicaid
1271 claims data and other data, concerning the quality of care and services

1272 provided by health care providers, for the purpose of supporting
1273 quality improvement initiatives and enabling consumers to make
1274 informed choices with respect to such health care providers; (2)
1275 provide comparative data to health care providers concerning the
1276 quality of their performance relative to their peers; (3) be responsible
1277 for collecting and analyzing data from hospitals pertaining to
1278 nosocomial infections for the purpose of tracking, reporting and
1279 reducing nosocomial infection rates; (4) be responsible for collecting
1280 and analyzing such data from other health care providers, as it deems
1281 necessary; (5) be responsible for annually selecting state-wide quality
1282 improvement initiatives and encouraging all health plans to adopt
1283 such quality improvement initiatives with the same goals and metrics;
1284 (6) seek funding from private and federal funding sources; and (7) seek
1285 accreditation not later than July 1, 2012, by the National Committee for
1286 Quality Assurance as a Quality Plus program.

1287 Sec. 20. (NEW) (*Effective October 1, 2007*) (a) Not later than January 1,
1288 2008, and every five years thereafter, the Office of Health Care Access
1289 shall determine the number of residents of this state who are not
1290 covered by a health insurance plan. If the number of uninsured
1291 residents has not decreased by fifty per cent by October 1, 2013, the
1292 Health Care Reform Commission shall determine whether it is
1293 advisable to require all or certain residents to have health insurance.
1294 Not later than January 1, 2014, the commission shall report its findings
1295 and recommendations to the joint standing committee of the General
1296 Assembly having cognizance of matters relating to insurance, in
1297 accordance with section 11-4a of the general statutes.

1298 (b) Not later than December 31, 2008, and annually thereafter, the
1299 Office of Health Care Access shall conduct a survey to determine the
1300 number of employers in the state providing health care benefits to
1301 employees who reside in this state. Not later than January 1, 2009, and
1302 annually thereafter, the office shall submit a report of its findings to
1303 the joint standing committee of the General Assembly having
1304 cognizance of matters relating to insurance, in accordance with section
1305 11-4a of the general statutes.

1306 Sec. 21. (NEW) (*Effective October 1, 2007*) No physician licensed
1307 under chapter 370 of the general statutes and no hospital licensed
1308 under chapter 368v of the general statutes that provides medical
1309 services or treatment to persons who do not have health insurance
1310 coverage shall charge fees for such services or treatment that exceed
1311 two hundred per cent of those fees allowed by the federal Medicare
1312 program for such services or treatment or the contract amount with
1313 any commercial payor, whichever is greater.

1314 Sec. 22. (*Effective July 1, 2007*) (a) The Commissioner of Public Health
1315 shall identify and evaluate current programs that provide services to
1316 residents of this state who are uninsured.

1317 (b) Not later than January 1, 2008, said commissioner shall submit a
1318 report of findings and recommendations to the joint standing
1319 committees of the General Assembly having cognizance of matters
1320 relating to public health and appropriations and the budgets of state
1321 agencies. Such report shall identify the programs that are likely to
1322 experience a decrease in utilization due to the implementation of the
1323 programs and plans established under the Connecticut Healthy Steps
1324 Program and the amount of such decrease, to the extent feasible.

1325 Sec. 23. (NEW) (*Effective July 1, 2007*) The Office of Health Care
1326 Access shall utilize the data obtained pursuant to section 20 of this act
1327 relative to any decreases in the number of uninsured residents of this
1328 state to make recommendations to the Department of Social Services
1329 for commensurate decreases in the disproportionate share payments to
1330 hospitals in accordance with the provisions of section 19a-671 of the
1331 general statutes.

1332 Sec. 24. (NEW) (*Effective July 1, 2007*) Not later than December 31,
1333 2007, the Commissioner of Social Services shall seek a waiver or
1334 waivers of federal Medicaid rules for the purpose of (1) obtaining any
1335 available federal reimbursement, including federal financial
1336 participation, for state expenditures related to the health savings
1337 account incentive program established under section 8 of this act and

1338 the premium subsidy program established under section 9 of this act,
1339 and (2) establishing a state excess cost reinsurance program for
1340 enrollees in the Connecticut Connector's affordable health care plan to
1341 allow such enrollees to obtain coverage through the Medicaid program
1342 once their insurance benefits are exhausted without having to spend
1343 down their assets.

1344 Sec. 25. (NEW) (*Effective July 1, 2007*) (a) The Commissioner of Social
1345 Services shall develop a plan to improve the coordination of the
1346 delivery of health care services to all or a substantial subset of the
1347 aged, blind and disabled Medicaid beneficiaries. Such plan shall
1348 include programs to (1) improve coordination of and access to medical
1349 services, social services and housing, (2) implement chronic disease
1350 management programs, (3) use predictive modeling to identify high
1351 risk, complex and high-cost Medicaid beneficiaries, and (4) provide
1352 such beneficiaries with intensive clinical care coordination and
1353 pharmacological management. The commissioner may contract with
1354 an administrative services organization to effectuate the
1355 implementation of such plan.

1356 (b) Such plan shall also address:

1357 (1) Provider reimbursement systems that are aligned with the goal
1358 of managing the care of individuals who have, or are at risk for having,
1359 chronic health conditions in order to improve health outcomes and the
1360 quality of care for such individuals; and

1361 (2) The use and development of outcome measures and reporting
1362 requirements, aligned with existing outcome measures within the
1363 Departments of Social Services, to assess and evaluate the system of
1364 chronic care.

1365 (c) Not later than January 1, 2008, the Commissioner of Social
1366 Services shall submit such plan, in accordance with section 11-4a of the
1367 general statutes, to the joint standing committees of the General
1368 Assembly having cognizance of matters relating to human services and
1369 appropriations and the budgets of state agencies. On October 1, 2009,

1370 and annually thereafter, the Commissioner of Social Services shall
1371 report, in accordance with the provisions of section 11-4a of the general
1372 statutes, on the status of implementation of such plan to the joint
1373 standing committees of the General Assembly having cognizance of
1374 matters relating to human services and appropriations and the budgets
1375 of state agencies. The report shall include the number of individuals
1376 and health care providers participating in the programs specified in
1377 subsection (a) of this section, indicators of quality improvement and
1378 patient satisfaction, annual expenditures and savings associated with
1379 the plan and such other information as may be requested by said joint
1380 standing committees.

1381 Sec. 26. (NEW) (*Effective July 1, 2007*) On and after January 1, 2008,
1382 the Commissioner of Social Services shall allow aged, blind or disabled
1383 Medicaid beneficiaries to voluntarily enroll in the managed care plans
1384 available to HUSKY Plan, Part A and HUSKY Plan, Part B
1385 beneficiaries.

1386 Sec. 27. Section 17b-192 of the general statutes is repealed and the
1387 following is substituted in lieu thereof (*Effective July 1, 2007*):

1388 (a) The Commissioner of Social Services shall implement a state
1389 medical assistance component of the state-administered general
1390 assistance program for persons ineligible for Medicaid. [Not later than
1391 October 1, 2003, each] Eligibility criteria concerning income shall be the
1392 same as the medically needy component of the Medicaid program as
1393 utilized on June 30, 2007, except that earned monthly gross income of
1394 up to one hundred fifty dollars shall be disregarded. Unearned income
1395 shall not be disregarded. No person who has family assets exceeding
1396 one thousand dollars shall be eligible. No person shall be eligible for
1397 assistance under this section if such person made, during the three
1398 months prior to the month of application, an assignment or transfer or
1399 other disposition of property for less than fair market value. The
1400 number of months of ineligibility due to such disposition shall be
1401 determined by dividing the fair market value of such property, less
1402 any consideration received in exchange for its disposition, by five

1403 hundred dollars. Such period of ineligibility shall commence in the
1404 month in which the person is otherwise eligible for benefits. Any
1405 assignment, transfer or other disposition of property, on the part of the
1406 transferor, shall be presumed to have been made for the purpose of
1407 establishing eligibility for benefits or services unless such person
1408 provides convincing evidence to establish that the transaction was
1409 exclusively for some other purpose.

1410 (b) Each person eligible for state-administered general assistance
1411 shall be entitled to receive medical care through a federally qualified
1412 health center or other primary care provider as determined by the
1413 commissioner. The Commissioner of Social Services shall determine
1414 appropriate service areas and shall, in the commissioner's discretion,
1415 contract with community health centers, other similar clinics, and
1416 other primary care providers, if necessary, to assure access to primary
1417 care services for recipients who live farther than a reasonable distance
1418 from a federally qualified health center. The commissioner shall assign
1419 and enroll eligible persons in federally qualified health centers and
1420 with any other providers contracted for the program because of access
1421 needs. [Not later than October 1, 2003, each] Each person eligible for
1422 state-administered general assistance shall be entitled to receive
1423 hospital services. The Commissioner of Social Services may impose
1424 copayments on persons eligible for medical assistance under the state-
1425 administered general assistance program who utilize the emergency
1426 room of a hospital to access services of a nonemergency nature.
1427 Services of a nonemergency nature shall be defined by the
1428 commissioner after consultation with representative staff of emergency
1429 rooms throughout the state. Prior to imposing any such copayments,
1430 the commissioner shall provide not less than thirty days written notice
1431 to all persons eligible for medical assistance under the state-
1432 administered general assistance program advising such persons of the
1433 impending implementation of copayments and the department's
1434 policies that will be applicable to such copayments. The first instance
1435 of emergency room use by an eligible person to access services of a
1436 nonemergency nature shall not result in the imposition of a

1437 copayment, but the staff at such emergency room shall provide verbal
1438 and written notice to such person, in a manner prescribed by the
1439 commissioner, that advises such person that continued use of the
1440 emergency room for services of a nonemergency nature shall result in
1441 the imposition of copayments payable by such person and that such
1442 person should seek nonemergency care from the federally qualified
1443 health center or any other provider assigned to provide medical care to
1444 such person by the commissioner. Any copayment imposed pursuant
1445 to this subsection shall not exceed the sum of six dollars per visit. The
1446 commissioner shall not deduct any copayment imposed pursuant to
1447 this subsection from payments that are due and owing from the
1448 department to such emergency room. Medical services under the
1449 program shall be limited to the services provided by a federally
1450 qualified health center, hospital, or other provider contracted for the
1451 program at the commissioner's discretion because of access needs. The
1452 commissioner shall ensure that ancillary services and specialty services
1453 are provided by a federally qualified health center, hospital, or other
1454 providers contracted for the program at the commissioner's discretion.
1455 Ancillary services include, but are not limited to, radiology, laboratory,
1456 and other diagnostic services not available from a recipient's assigned
1457 primary-care provider, and durable medical equipment. Specialty
1458 services are services provided by a physician with a specialty that are
1459 not included in ancillary services. In no event shall ancillary or
1460 specialty services provided under the program exceed such services
1461 provided under the state-administered general assistance program on
1462 July 1, 2003. [Eligibility criteria concerning income shall be the same as
1463 the medically needy component of the Medicaid program, except that
1464 earned monthly gross income of up to one hundred fifty dollars shall
1465 be disregarded. Unearned income shall not be disregarded. No person
1466 who has family assets exceeding one thousand dollars shall be eligible.
1467 No person eligible for Medicaid shall be eligible to receive medical
1468 care through the state-administered general assistance program. No
1469 person shall be eligible for assistance under this section if such person
1470 made, during the three months prior to the month of application, an
1471 assignment or transfer or other disposition of property for less than

1472 fair market value. The number of months of ineligibility due to such
1473 disposition shall be determined by dividing the fair market value of
1474 such property, less any consideration received in exchange for its
1475 disposition, by five hundred dollars. Such period of ineligibility shall
1476 commence in the month in which the person is otherwise eligible for
1477 benefits. Any assignment, transfer or other disposition of property, on
1478 the part of the transferor, shall be presumed to have been made for the
1479 purpose of establishing eligibility for benefits or services unless such
1480 person provides convincing evidence to establish that the transaction
1481 was exclusively for some other purpose.]

1482 [(b) Recipients covered by a general assistance program operated by
1483 a town shall be assigned and enrolled in federally qualified health
1484 centers and with any other providers in the same manner as recipients
1485 of medical assistance under the state-administered general assistance
1486 program pursuant to subsection (a) of this section.]

1487 (c) [On and after October 1, 2003, pharmacy] Pharmacy services
1488 shall be provided to recipients of state-administered general assistance
1489 through the federally qualified health center to which they are
1490 assigned or through a pharmacy with which the health center
1491 contracts. Prior to said date, pharmacy services shall be provided as
1492 provided under the Medicaid program. Recipients who are assigned to
1493 a community health center or similar clinic or primary care provider
1494 other than a federally qualified health center or to a federally qualified
1495 health center that does not have a contract for pharmacy services shall
1496 receive pharmacy services at pharmacies designated by the
1497 commissioner. The Commissioner of Social Services or the managed
1498 care organization or other entity performing administrative functions
1499 for the program as permitted in subsection (d) of this section, shall
1500 require prior authorization for coverage of drugs for the treatment of
1501 erectile dysfunction. The commissioner or the managed care
1502 organization or other entity performing administrative functions for
1503 the program may limit or exclude coverage for drugs for the treatment
1504 of erectile dysfunction for persons who have been convicted of a sexual
1505 offense who are required to register with the Commissioner of Public

1506 Safety pursuant to chapter 969.

1507 (d) The Commissioner of Social Services shall contract with
1508 federally qualified health centers or other primary care providers as
1509 necessary to provide medical services to eligible state-administered
1510 general assistance recipients pursuant to this section. The
1511 commissioner shall, within available appropriations, make payments
1512 to such centers based on their pro rata share of the cost of services
1513 provided or the number of clients served, or both. The Commissioner
1514 of Social Services shall, within available appropriations, make
1515 payments to other providers based on a methodology determined by
1516 the commissioner. The Commissioner of Social Services may reimburse
1517 for extraordinary medical services, provided such services are
1518 documented to the satisfaction of the commissioner. For purposes of
1519 this section, the commissioner may contract with a managed care
1520 organization or other entity to perform administrative functions,
1521 including a grievance process for recipients to access review of a denial
1522 of coverage for a specific medical service, and to operate the program
1523 in whole or in part. Provisions of a contract for medical services
1524 entered into by the commissioner pursuant to this section shall
1525 supersede any inconsistent provision in the regulations of Connecticut
1526 state agencies. A recipient who has exhausted the grievance process
1527 established through such contract and wishes to seek further review of
1528 the denial of coverage for a specific medical service may request a
1529 hearing in accordance with the provisions of section 17b-60.

1530 (e) Each federally qualified health center participating in the
1531 program shall [, within thirty days of August 20, 2003,] enroll in the
1532 federal Office of Pharmacy Affairs Section 340B drug discount
1533 program established pursuant to 42 USC 256b to provide pharmacy
1534 services to recipients at Federal Supply Schedule costs. Each such
1535 health center may establish an on-site pharmacy or contract with a
1536 commercial pharmacy to provide such pharmacy services.

1537 (f) The Commissioner of Social Services shall, within available
1538 appropriations, make payments to hospitals for inpatient services

1539 based on their pro rata share of the cost of services provided or the
1540 number of clients served, or both. The Commissioner of Social Services
1541 shall, within available appropriations, make payments for any
1542 ancillary or specialty services provided to state-administered general
1543 assistance recipients under this section based on a methodology
1544 determined by the commissioner.

1545 (g) On or before March 1, 2004, the Commissioner of Social Services
1546 shall seek a waiver of federal law under the Health Insurance
1547 Flexibility and Accountability demonstration initiative for the purpose
1548 of extending health insurance coverage under Medicaid to persons
1549 qualifying for medical assistance under the state-administered general
1550 assistance program. The provisions of section 17b-8 shall apply to this
1551 section.

1552 (h) The commissioner, pursuant to section 17b-10, may implement
1553 policies and procedures to administer the provisions of this section
1554 while in the process of adopting such policies and procedures as
1555 regulation, provided the commissioner prints notice of the intent to
1556 adopt the regulation in the Connecticut Law Journal not later than
1557 twenty days after the date of implementation. Such policy and
1558 procedures shall be valid until the time final regulations are adopted.

1559 Sec. 28. Section 17b-261 of the general statutes is repealed and the
1560 following is substituted in lieu thereof (*Effective July 1, 2007*):

1561 (a) Medical assistance shall be provided for any otherwise eligible
1562 person whose income, including any available support from legally
1563 liable relatives and the income of the person's spouse or dependent
1564 child, is not more than one hundred forty-three per cent, pending
1565 approval of a federal waiver applied for pursuant to subsection (d) of
1566 this section, of the benefit amount paid to a person with no income
1567 under the temporary family assistance program in the appropriate
1568 region of residence and if such person is an institutionalized
1569 individual as defined in Section 1917(c) of the Social Security Act, 42
1570 USC 1396p(c), and has not made an assignment or transfer or other

1571 disposition of property for less than fair market value for the purpose
1572 of establishing eligibility for benefits or assistance under this section.
1573 Any such disposition shall be treated in accordance with Section
1574 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
1575 property made on behalf of an applicant or recipient or the spouse of
1576 an applicant or recipient by a guardian, conservator, person
1577 authorized to make such disposition pursuant to a power of attorney
1578 or other person so authorized by law shall be attributed to such
1579 applicant, recipient or spouse. A disposition of property ordered by a
1580 court shall be evaluated in accordance with the standards applied to
1581 any other such disposition for the purpose of determining eligibility.
1582 The commissioner shall establish the standards for eligibility for
1583 medical assistance at one hundred forty-three per cent of the benefit
1584 amount paid to a family unit of equal size with no income under the
1585 temporary family assistance program in the appropriate region of
1586 residence, [, pending federal approval, except that the] Except as
1587 provided in section 17b-277, as amended by this act, the medical
1588 assistance program shall provide coverage to persons under the age of
1589 nineteen [up to one hundred eighty-five per cent of the federal poverty
1590 level without an asset limit. Said medical assistance program shall also
1591 provide coverage to persons under the age of nineteen] and their
1592 parents and needy caretaker relatives, who qualify for coverage under
1593 Section 1931 of the Social Security Act, with family income up to one
1594 hundred [fifty] eighty-five per cent of the federal poverty level without
1595 an asset limit. [, upon the request of such a person or upon a
1596 redetermination of eligibility.] Such levels shall be based on the
1597 regional differences in such benefit amount, if applicable, unless such
1598 levels based on regional differences are not in conformance with
1599 federal law. Any income in excess of the applicable amounts shall be
1600 applied as may be required by said federal law, and assistance shall be
1601 granted for the balance of the cost of authorized medical assistance. All
1602 contracts entered into on and after July 1, 1997, pursuant to this section
1603 shall include provisions for collaboration of managed care
1604 organizations with the Nurturing Families Network established
1605 pursuant to section 17a-56. The Commissioner of Social Services shall

1606 provide applicants for assistance under this section, at the time of
1607 application, with a written statement advising them of (1) the effect of
1608 an assignment or transfer or other disposition of property on eligibility
1609 for benefits or assistance, and (2) the availability of, and eligibility for,
1610 services provided by the Nurturing Families Network established
1611 pursuant to section 17a-56.

1612 (b) For the purposes of the Medicaid program, the Commissioner of
1613 Social Services shall consider parental income and resources as
1614 available to a child under eighteen years of age who is living with his
1615 or her parents and is blind or disabled for purposes of the Medicaid
1616 program, or to any other child under twenty-one years of age who is
1617 living with his or her parents.

1618 (c) For the purposes of determining eligibility for the Medicaid
1619 program, an available asset is one that is actually available to the
1620 applicant or one that the applicant has the legal right, authority or
1621 power to obtain or to have applied for the applicant's general or
1622 medical support. If the terms of a trust provide for the support of an
1623 applicant, the refusal of a trustee to make a distribution from the trust
1624 does not render the trust an unavailable asset. Notwithstanding the
1625 provisions of this subsection, the availability of funds in a trust or
1626 similar instrument funded in whole or in part by the applicant or the
1627 applicant's spouse shall be determined pursuant to the Omnibus
1628 Budget Reconciliation Act of 1993, 42 USC 1396p. The provisions of
1629 this subsection shall not apply to special needs trust, as defined in 42
1630 USC 1396p(d)(4)(A).

1631 (d) The transfer of an asset in exchange for other valuable
1632 consideration shall be allowable to the extent the value of the other
1633 valuable consideration is equal to or greater than the value of the asset
1634 transferred.

1635 (e) The Commissioner of Social Services shall seek a waiver from
1636 federal law to permit federal financial participation for Medicaid
1637 expenditures for families with incomes of one hundred forty-three per

1638 cent of the temporary family assistance program payment standard.

1639 (f) To the extent permitted by federal law, Medicaid eligibility shall
1640 be extended for one year to a family that becomes ineligible for
1641 medical assistance under Section 1931 of the Social Security Act due to
1642 income from employment by one of its members who is a caretaker
1643 relative or due to receipt of child support income. A family receiving
1644 extended benefits on July 1, 2005, shall receive the balance of such
1645 extended benefits, provided no such family shall receive more than
1646 twelve additional months of such benefits.

1647 (g) An institutionalized spouse applying for Medicaid and having a
1648 spouse living in the community shall be required, to the maximum
1649 extent permitted by law, to divert income to such community spouse
1650 in order to raise the community spouse's income to the level of the
1651 minimum monthly needs allowance, as described in Section 1924 of
1652 the Social Security Act. Such diversion of income shall occur before the
1653 community spouse is allowed to retain assets in excess of the
1654 community spouse protected amount described in Section 1924 of the
1655 Social Security Act. The Commissioner of Social Services, pursuant to
1656 section 17b-10, may implement the provisions of this subsection while
1657 in the process of adopting regulations, provided the commissioner
1658 prints notice of intent to adopt the regulations in the Connecticut Law
1659 Journal within twenty days of adopting such policy. Such policy shall
1660 be valid until the time final regulations are effective.

1661 (h) The Commissioner of Social Services shall, to the extent
1662 permitted by federal law, or, pursuant to an approved waiver of
1663 federal law submitted by the commissioner, in accordance with the
1664 provisions of section 17b-8, impose the following cost-sharing
1665 requirements under the HUSKY Plan, on all parent and needy
1666 caretaker relatives with incomes exceeding one hundred per cent of the
1667 federal poverty level: (1) A twenty-five-dollar premium per month per
1668 parent or needy caretaker relative; and (2) a copayment of one dollar
1669 per visit for outpatient medical services delivered by an enrolled
1670 Medicaid or HUSKY Plan provider. The commissioner may implement

1671 policies and procedures necessary to administer the provisions of this
1672 subsection while in the process of adopting such policies and
1673 procedures as regulations, provided the commissioner publishes notice
1674 of the intent to adopt regulations in the Connecticut Law Journal not
1675 later than twenty days after implementation. Policies and procedures
1676 implemented pursuant to this subsection shall be valid until the time
1677 final regulations are adopted.

1678 (i) Medical assistance shall be provided, in accordance with the
1679 provisions of subsection (e) of section 17a-6, to any child under the
1680 supervision of the Commissioner of Children and Families who is not
1681 receiving Medicaid benefits, has not yet qualified for Medicaid benefits
1682 or is otherwise ineligible for such benefits because of institutional
1683 status. To the extent practicable, the Commissioner of Children and
1684 Families shall apply for, or assist such child in qualifying for, the
1685 Medicaid program.

1686 (j) The Commissioner of Social Services shall provide Early and
1687 Periodic Screening, Diagnostic and Treatment program services, as
1688 required and defined as of December 31, 2005, by 42 USC 1396a(a)(43),
1689 42 USC 1396d(r) and 42 USC 1396d(a)(4)(B) and applicable federal
1690 regulations, to all persons who are under the age of twenty-one and
1691 otherwise eligible for medical assistance under this section.

1692 (k) Notwithstanding the provisions of this section, the
1693 Commissioner of Social Services, pursuant to 42 USC 1396a(r)(2), shall
1694 file an amendment to the Medicaid state plan that allows the
1695 commissioner, when making Medicaid income eligibility
1696 determinations, to establish a special income disregard applicable only
1697 to the Medicaid program that permits individuals who are aged, blind
1698 or disabled and who have income that does not exceed one hundred
1699 fifty per cent of the federal poverty level to qualify for Medicaid.

1700 (l) To the extent permitted by federal law, the Commissioner of
1701 Social Services may impose copayments on persons eligible for
1702 medical assistance under the provisions of this section who utilize the

1703 emergency room of a hospital to access services of a nonemergency
1704 nature. Services of a nonemergency nature shall be defined by the
1705 commissioner after consultation with representative staff of emergency
1706 rooms throughout the state. Prior to imposing any such copayments,
1707 the commissioner shall provide not less than thirty days written notice
1708 to all persons eligible for medical assistance under this section
1709 advising such persons of the impending implementation of
1710 copayments and the Department of Social Services policies that will be
1711 applicable to such copayments. The first instance of emergency room
1712 use by an eligible person to access services of a nonemergency nature
1713 shall not result in the imposition of a copayment, but the staff at such
1714 emergency room shall provide verbal and written notice, in a manner
1715 prescribed by the commissioner, that advises such person that
1716 continued use of the emergency room for services of a nonemergency
1717 nature shall result in the imposition of copayments on the recipient
1718 and that such person should seek nonemergency care from other
1719 providers assigned to provide medical assistance to such person in
1720 accordance with the provisions of this section. Any copayment
1721 imposed pursuant to this subsection shall not exceed the sum of
1722 twenty-five dollars per visit and the commissioner shall have the
1723 discretion to establish a sliding scale for copayment based on a
1724 person's income level. The commissioner shall not deduct any
1725 copayment imposed pursuant to this subsection from payments that
1726 are due and owing from the department to such emergency room.

1727 Sec. 29. Section 17b-277 of the general statutes is repealed and the
1728 following is substituted in lieu thereof (*Effective July 1, 2007*):

1729 (a) The Commissioner of Social Services shall provide, in accordance
1730 with federal law and regulations, medical assistance under the
1731 Medicaid program to needy pregnant women and children up to one
1732 year of age whose families have an income up to one hundred eighty-
1733 five per cent of the federal poverty level. On or before January 1, 2008,
1734 the Commissioner of Social Services, shall seek a waiver under federal
1735 law under the Health Insurance Flexibility and Accountability
1736 demonstration proposal to provide health insurance coverage to

1737 pregnant women, who do not otherwise have creditable coverage, as
1738 defined in 42 USC 300gg(c), and with incomes above one hundred
1739 eighty-five per cent of the federal poverty level but not in excess of
1740 three hundred per cent of the federal poverty level. The waiver
1741 submitted by the commissioner shall specify that funding for such
1742 health insurance coverage shall be provided through a reallocation of
1743 unspent state children's health insurance plan funds. In the event such
1744 waiver is approved, the Commissioner of Social Services shall provide
1745 medical assistance under the Medicaid program to needy pregnant
1746 women with income not exceeding three hundred per cent of the
1747 federal poverty level.

1748 (b) The commissioner shall expedite eligibility for appropriate
1749 pregnant women applicants for the Medicaid program. The process for
1750 making expedited eligibility determinations concerning needy
1751 pregnant women shall ensure that emergency applications for
1752 assistance, as determined by the commissioner, shall be processed no
1753 later than twenty-four hours after receipt of all required information
1754 from the applicant, and that nonemergency applications for assistance,
1755 as determined by the commissioner, shall be processed no later than
1756 five calendar days after the date of receipt of all required information
1757 from the applicant.

1758 (c) Presumptive eligibility for medical assistance shall be
1759 implemented for any uninsured newborn child born in a hospital in
1760 this state or a border state hospital provided (1) the child's family
1761 resides in this state, and (2) a parent of such child authorizes
1762 enrollment in the program.

1763 [(c)] (d) The commissioner shall submit biannual reports to the
1764 council, established pursuant to section 17b-28, on the department's
1765 compliance with the administrative processing requirements set forth
1766 in subsection (b) of this section.

1767 Sec. 30. Section 17b-292 of the general statutes is repealed and the
1768 following is substituted in lieu thereof (*Effective July 1, 2007*):

1769 (a) A child who resides in a household with a family income which
1770 exceeds one hundred eighty-five per cent of the federal poverty level
1771 and does not exceed three hundred per cent of the federal poverty
1772 level may be eligible for subsidized benefits under the HUSKY Plan,
1773 Part B.

1774 (b) A child who resides in a household with a family income over
1775 three hundred per cent of the federal poverty level may be eligible for
1776 unsubsidized benefits under the HUSKY Plan, Part B.

1777 (c) Whenever a court or family support magistrate orders a
1778 noncustodial parent to provide health insurance for a child, such
1779 parent may provide for coverage under the HUSKY Plan, Part B.

1780 (d) On and after January 1, 2008, a child who was determined to be
1781 eligible for benefits under either the HUSKY Plan, Part A or Part B
1782 shall remain eligible for such plan for a period of twelve months from
1783 such child's determination of eligibility unless the child attains the age
1784 of nineteen or is no longer a resident of the state. An adult who has
1785 been determined to be eligible for benefits under the HUSKY Plan, Part
1786 A shall, unless otherwise precluded under federal law, remain eligible
1787 for such plan for a period of twelve months from such adult's
1788 determination of eligibility unless the adult is no longer a resident of
1789 the state. During the twelve-month period following the date that an
1790 adult or child is determined eligible for the HUSKY Plan, Part A or
1791 Part B, the adult or family of such child shall comply with federal
1792 requirements concerning the reporting of information to the
1793 department, including, but not limited to, change of address
1794 information.

1795 ~~[(d)]~~ (e) To the extent allowed under federal law, the commissioner
1796 shall not pay for services or durable medical equipment under the
1797 HUSKY Plan, Part B if the enrollee has other insurance coverage for
1798 the services or such equipment.

1799 ~~[(e)]~~ (f) A newborn child who otherwise meets the eligibility criteria
1800 for the HUSKY Plan, Part B shall be eligible for benefits retroactive to

1801 his date of birth, provided an application is filed on behalf of the child
1802 [within] not later than thirty days [of] after such date. Any uninsured
1803 child born in a hospital in this state or in a border state hospital shall
1804 be enrolled by an expedited process in the HUSKY Plan, Part B
1805 provided (1) the child's family resides in this state, and (2) a parent of
1806 such child authorizes enrollment in the program. The commissioner
1807 shall pay any premium cost such family would otherwise incur for the
1808 first two months of coverage to the managed care organization selected
1809 by the family to provide coverage for such child.

1810 [(f)] (g) The commissioner shall implement presumptive eligibility
1811 for children applying for Medicaid. Such presumptive eligibility
1812 determinations shall be in accordance with applicable federal law and
1813 regulations. The commissioner shall adopt regulations, in accordance
1814 with chapter 54, to establish standards and procedures for the
1815 designation of organizations as qualified entities to grant presumptive
1816 eligibility. Qualified entities shall ensure that, at the time a
1817 presumptive eligibility determination is made, a completed application
1818 for Medicaid is submitted to the department for a full eligibility
1819 determination. In establishing such standards and procedures, the
1820 commissioner shall ensure the representation of state-wide and local
1821 organizations that provide services to children of all ages in each
1822 region of the state.

1823 [(g)] (h) The commissioner shall enter into a contract with an entity
1824 to be a single point of entry servicer for applicants and enrollees under
1825 the HUSKY Plan, Part A and Part B. The servicer shall jointly market
1826 both Part A and Part B together as the HUSKY Plan. Such servicer shall
1827 develop and implement public information and outreach activities
1828 with community programs. Such servicer shall electronically transmit
1829 data with respect to enrollment and disenrollment in the HUSKY Plan,
1830 Part B to the commissioner.

1831 [(h)] (i) Upon the expiration of any contractual provisions entered
1832 into pursuant to subsection [(g)] (h) of this section, the commissioner
1833 shall develop a new contract for single point of entry services and

1834 managed care enrollment brokerage services. The commissioner may
1835 enter into one or more contractual arrangements for such services for a
1836 contract period not to exceed seven years. Such contracts shall include
1837 performance measures, including, but not limited to, specified time
1838 limits for the processing of applications, parameters setting forth the
1839 requirements for a completed and reviewable application and the
1840 percentage of applications forwarded to the department in a complete
1841 and timely fashion. Such contracts shall also include a process for
1842 identifying and correcting noncompliance with established
1843 performance measures, including sanctions applicable for instances of
1844 continued noncompliance with performance measures.

1845 [(i)] (j) The single point of entry servicer shall send an application
1846 and supporting documents to the commissioner for determination of
1847 eligibility of a child who resides in a household with a family income
1848 of one hundred eighty-five per cent or less of the federal poverty level.
1849 The servicer shall enroll eligible beneficiaries in the applicant's choice
1850 of managed care plan. Upon enrollment in a managed care plan, an
1851 eligible HUSKY Plan Part A or Part B beneficiary shall remain enrolled
1852 in such managed care plan for twelve months from the date of such
1853 enrollment unless (1) an eligible beneficiary demonstrates good cause
1854 to the satisfaction of the commissioner of the need to enroll in a
1855 different managed care plan, or (2) the beneficiary no longer meets
1856 program eligibility requirements.

1857 [(j)] (k) Not more than twelve months after the determination of
1858 eligibility for benefits under the HUSKY Plan, Part A and Part B and
1859 annually thereafter, the commissioner or the servicer, as the case may
1860 be, shall determine if the child continues to be eligible for the plan. The
1861 commissioner or the servicer shall mail an application form to each
1862 participant in the plan for the purposes of obtaining information to
1863 make a determination on eligibility. To the extent permitted by federal
1864 law, in determining eligibility for benefits under the HUSKY Plan, Part
1865 A or Part B with respect to family income, the commissioner or the
1866 servicer shall rely upon information provided in such form by the
1867 participant unless the commissioner or the servicer has reason to

1868 believe that such information is inaccurate or incomplete. The
1869 Department of Social Services shall annually review a random sample
1870 of cases to confirm that, based on the statistical sample, relying on such
1871 information is not resulting in ineligible clients receiving benefits
1872 under HUSKY Plan Part A or Part B. The determination of eligibility
1873 shall be coordinated with health plan open enrollment periods.

1874 [(k)] (l) The commissioner shall implement the HUSKY Plan, Part B
1875 while in the process of adopting necessary policies and procedures in
1876 regulation form in accordance with the provisions of section 17b-10.

1877 [(l)] (m) The commissioner shall adopt regulations, in accordance
1878 with chapter 54, to establish residency requirements and income
1879 eligibility for participation in the HUSKY Plan, Part B and procedures
1880 for a simplified mail-in application process. Notwithstanding the
1881 provisions of section 17b-257b, such regulations shall provide that any
1882 child adopted from another country by an individual who is a citizen
1883 of the United States and a resident of this state shall be eligible for
1884 benefits under the HUSKY Plan, Part B upon arrival in this state.

1885 Sec. 31. Section 17b-267 of the general statutes is repealed and the
1886 following is substituted in lieu thereof (*Effective July 1, 2008*):

1887 (a) If any group or association of providers of medical assistance
1888 services wishes to have payments as provided for under sections 17b-
1889 260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to
1890 17b-361, inclusive, to such providers made through a national, state or
1891 other public or private agency or organization and nominates such
1892 agency or organization for this purpose, the Commissioner of Social
1893 Services is authorized to enter into an agreement with such agency or
1894 organization providing for the determination by such agency or
1895 organization, subject to such review by the Commissioner of Social
1896 Services as may be provided for by the agreement, of the payments
1897 required to be made to such providers at the rates set by the hospital
1898 cost commission, and for the making of such payments by such agency
1899 or organization to such providers. Such agreement may also include

1900 provision for the agency or organization to do all or any part of the
1901 following: With respect to the providers of services which are to
1902 receive payments through it, (1) to serve as a center for, and to
1903 communicate to providers, any information or instructions furnished
1904 to it by the Commissioner of Social Services, and to serve as a channel
1905 of communication from providers to the Commissioner of Social
1906 Services; (2) to make such audits of the records of providers as may be
1907 necessary to insure that proper payments are made under this section;
1908 and (3) to perform such other functions as are necessary to carry out
1909 the provisions of sections 17b-267 to 17b-271, inclusive.

1910 (b) The Commissioner of Social Services shall not enter into an
1911 agreement with any agency or organization under subsection (a) of
1912 this section unless (1) he finds (A) that to do so is consistent with the
1913 effective and efficient administration of the medical assistance
1914 program, and (B) that such agency or organization is willing and able
1915 to assist the providers to which payments are made through it in the
1916 application of safeguards against unnecessary utilization of services
1917 furnished by them to individuals entitled to hospital insurance benefits
1918 under section 17b-261 and the agreement provides for such assistance,
1919 and (2) such agency or organization agrees to furnish to the
1920 Commissioner of Social Services such of the information acquired by it
1921 in carrying out its agreement under sections 17b-267 to 17b-271,
1922 inclusive, as the Commissioner of Social Services may find necessary in
1923 performing his functions under said sections.

1924 (c) An agreement with any agency or organization under subsection
1925 (a) of this section may contain such terms and conditions as the
1926 Commissioner of Social Services finds necessary or appropriate, may
1927 provide for advances of funds to the agency or organization for the
1928 making of payments by it under said subsection (a), and shall provide
1929 for payment by the Commissioner of Social Services of so much of the
1930 cost of administration of the agency or organization as is determined
1931 by the Commissioner of Social Services to be necessary and proper for
1932 carrying out the functions covered by the agreement.

1933 (d) Each managed care plan that enters into, renews or amends a
1934 contract with the Department of Social Services pursuant to this
1935 section shall limit its administrative costs to ten per cent of payments
1936 made pursuant to such contracts. The Commissioner of Social Services
1937 shall implement policies and procedures to effectuate the purpose of
1938 this subsection while in the process of adopting such policies or
1939 procedures in regulation form, provided notice of intention to adopt
1940 the regulations is printed in the Connecticut Law Journal not later than
1941 twenty days after implementation and any such policies and
1942 procedures shall be valid until the time the regulations are effective.
1943 The Commissioner of Social Services may define administrative costs
1944 to exclude disease management or other value-added clinical
1945 programs administered by the managed care plans, but not to exclude
1946 utilization management, claims, member services or other nonclinical
1947 functions.

1948 Sec. 32. (NEW) (*Effective July 1, 2007*) (a) Effective January 1, 2008,
1949 the Commissioner of Social Services shall increase the Medicaid fee-
1950 for-service reimbursement schedule for dental services. The schedule
1951 shall provide for a fee for each dental service provided on or after
1952 January 1, 2008, except for an orthodontic service, that is equal to the
1953 seventieth percentile of normal and customary private provider fees,
1954 as defined by the National Dental Advisory Service Comprehensive
1955 Fee Report. The rates of reimbursement paid in accordance with this
1956 subsection to dentists under the Medicaid fee-for-service program
1957 shall be annually adjusted to reflect increases in the consumer price
1958 index for medical care.

1959 (b) Effective January 1, 2008, the Commissioner of Social Services
1960 shall increase the Medicaid fee-for-service reimbursement schedule for
1961 physician services to a level that is equivalent to ninety per cent of 2007
1962 rates in aggregate for comparable physician services under the
1963 Medicare program. The schedule for physician services shall be based
1964 on the resource based relative value scale system utilized under the
1965 Medicare program, modified by adjusting the relative value unit
1966 weights as necessary to reflect the unique characteristics of the

1967 Medicaid population; provided the effect of any such adjustment does
1968 not result in a physician service reimbursement rate increase that
1969 exceeds ninety per cent of the rate paid to physicians for such service
1970 under the Medicare program. Such adjustment shall be based on the
1971 recommendation of an advisory committee convened by the
1972 commissioner. The advisory committee shall consist of physicians and
1973 reimbursement specialists. The commissioner may use a higher
1974 conversion factor to calculate reimbursement rates for primary care
1975 physicians, pediatricians, obstetricians, family practitioners, and
1976 general internists than the conversion factor used to calculate
1977 reimbursement rates for specialists. The rates of reimbursement paid in
1978 accordance with this subsection to physicians under the Medicaid fee-
1979 for-service program shall be annually adjusted to reflect percentage
1980 increases in comparable Medicare rates, if any, and if there are no
1981 percentage increases in the comparable Medicare rates, the rates of
1982 reimbursement shall be annually adjusted utilizing the consumer price
1983 index for medical care, provided such rates shall not exceed the rates
1984 paid for comparable services under the Medicare program. The
1985 commissioner may withhold up to five per cent of the amount to be
1986 paid to physicians pursuant to this subsection and use such funds to
1987 establish a pay-for-performance bonus program that rewards
1988 physicians who use electronic prescribing, establish disease registries,
1989 offer weekend and evening hours, or meet benchmarks for
1990 appointment availability for urgent care. The commissioner shall
1991 distribute all moneys withheld to establish such bonus program to
1992 those physicians who qualify for a pay-for-performance bonus.

1993 (c) Effective January 1, 2008, the Commissioner of Social Services
1994 shall increase the Medicaid fee-for-service reimbursement schedule for
1995 hospital services to a level that is equivalent to ninety per cent of 2007
1996 rates in aggregate for comparable hospital services under the Medicare
1997 program. The rates of reimbursement paid in accordance with this
1998 subsection to hospitals under the Medicaid fee-for-service program
1999 shall be annually adjusted to reflect percentage increases in
2000 comparable Medicare rates, if any, and if there are no percentage

2001 increases in comparable Medicare rates, the rates of reimbursement
2002 shall be annually adjusted utilizing the consumer price index for
2003 medical care, provided such rates shall not exceed the rates paid to
2004 hospitals for comparable services under the Medicare program. The
2005 commissioner may withhold up to twenty per cent of the amount to be
2006 paid to hospitals pursuant to this subsection and use such funds to
2007 establish a pay-for-performance bonus program that rewards hospitals
2008 that utilize computerized physician order entry systems, meet
2009 benchmarks related to hospital infection rates, or meet other
2010 requirements as may be established by the commissioner.

2011 (d) On and after January 1, 2008, the Commissioner of Social
2012 Services shall amend each contract with a managed care plan entered
2013 into pursuant to section 17b-266 of the general statutes, upon renewal,
2014 to require each managed care plan to increase reimbursement to
2015 dentists, physicians, and hospitals to at least the same levels specified
2016 in subsections (a) to (c), inclusive, of this section.

2017 Sec. 33. Section 17b-297 of the general statutes is repealed and the
2018 following is substituted in lieu thereof (*Effective July 1, 2007*):

2019 (a) The [commissioner] Commissioner of Social Services, in
2020 consultation with the Children's Health Council, the Medicaid
2021 Managed Care Council and the 2-1-1 Infoline [of Connecticut]
2022 program, shall develop mechanisms [for outreach for] to increase
2023 outreach and maximize enrollment of eligible children and adults in
2024 the HUSKY Plan, Part A [and] or Part B. [, including, but not limited
2025 to, development of mail-in applications and appropriate outreach
2026 materials through the Department of Revenue Services, the Labor
2027 Department, the Department of Social Services, the Department of
2028 Public Health, the Department of Children and Families and the Office
2029 of Protection and Advocacy for Persons with Disabilities.] Such
2030 mechanisms shall include, but not be limited to, the development and
2031 implementation of mail-in and on-line application systems. In
2032 addition, the Commissioner of Social Services shall develop
2033 appropriate outreach materials and, in collaboration with the

2034 Departments of Public Health, Children and Families, Mental Health
2035 and Addiction Services, Mental Retardation, Education, Revenue
2036 Services and Motor Vehicles, the Labor Department and the Office of
2037 Protection and Advocacy for Persons with Disabilities and, as
2038 appropriate, disseminate such outreach materials. All outreach
2039 materials shall be approved by the commissioner pursuant to Subtitle J
2040 of Public Law 105-33.

2041 (b) The commissioner shall include in such outreach efforts
2042 information on the Medicaid program for the purpose of maximizing
2043 enrollment of eligible children and the use of federal funds.

2044 (c) The commissioner shall, within available appropriations,
2045 contract with severe need schools and community-based organizations
2046 for purposes of public education, outreach and recruitment of eligible
2047 children, including the distribution of applications and information
2048 regarding enrollment in the HUSKY Plan, Part A and Part B. In
2049 awarding such contracts, the commissioner shall consider the
2050 marketing, outreach and recruitment efforts of organizations. For the
2051 purposes of this subsection, (1) "community-based organizations" shall
2052 include, but not be limited to, day care centers, schools, school-based
2053 health clinics, community-based diagnostic and treatment centers and
2054 hospitals, and (2) "severe need school" means a school in which forty
2055 per cent or more of the lunches served are served to students who are
2056 eligible for free or reduced price lunches.

2057 [(d) All outreach materials shall be approved by the commissioner
2058 pursuant to Subtitle J of Public Law 105-33.]

2059 (d) Not later than July 1, 2008, the commissioner shall award fifty
2060 grants in amounts not to exceed ten thousand dollars per grant to
2061 community-based organizations for the purposes of promoting
2062 increased public education, outreach and recruitment of eligible
2063 children, distribution of applications and information regarding
2064 enrollment in the HUSKY Plan, Part A and Part B.

2065 (e) Not later than [January 1, 1999] July 1, 2008, and annually

2066 thereafter, the commissioner shall submit a report to the Governor and
2067 the General Assembly on the implementation of and the results of the
2068 community-based outreach program specified in subsections (a) to [(c)]
2069 (d), inclusive, of this section.

2070 Sec. 34. Section 17b-297b of the general statutes is repealed and the
2071 following is substituted in lieu thereof (*Effective July 1, 2007*):

2072 (a) Each local or regional board of education or similar body
2073 governing a nonpublic school or schools shall, at the beginning of each
2074 school year, provide to the parent or guardian of any pupil attending
2075 such school: (1) Outreach materials concerning eligibility for health
2076 insurance coverage under the HUSKY Plan, Part A or Part B, or (2)
2077 notice of the availability of such outreach materials. Such outreach
2078 materials shall be developed by the Department of Social Services in
2079 accordance with the provisions of sections 17b-297, as amended by this
2080 act, and disseminated by the department to schools.

2081 [(a)] (b) To the extent permitted by federal law, the Commissioners
2082 of Social Services and Education shall jointly establish procedures for
2083 the sharing of information contained in applications for free and
2084 reduced price meals under the National School Lunch Program for the
2085 purpose of determining whether children participating in said
2086 program are eligible for coverage under the HUSKY Plan, Part A and
2087 Part B. The Commissioner of Social Services shall take all actions
2088 necessary to ensure that children identified as eligible for the HUSKY
2089 Plan are able to enroll in said plan.

2090 [(b)] (c) The Commissioner of Education shall establish procedures
2091 whereby an individual may apply for the HUSKY Plan, Part A or Part
2092 B, at the same time such individual applies for the National School
2093 Lunch Program.

2094 Sec. 35. (NEW) (*Effective July 1, 2007*) (a) Not later than January 1,
2095 2008, the Commissioner of Social Services, in consultation with the
2096 Commissioner of Public Health, shall establish a joint program
2097 between public and private entities for the establishment and

2098 implementation of a multiyear, state-wide public information
2099 campaign for the purpose of promoting enrollment in the HUSKY
2100 Plan, Part A and Part B of all persons who may be eligible for such
2101 health insurance benefits.

2102 (b) Notwithstanding the provisions of sections 4-212 to 4-219,
2103 inclusive, of the general statutes, the Department of Social Services, in
2104 consultation with the Department of Public Health, shall solicit bids
2105 from private organizations for the design and operation of the media
2106 campaign. Such bids shall be solicited by sending notice to prospective
2107 organizations and by posting notice on public bulletin boards within
2108 the departments. Each bid shall be opened publicly at the time stated
2109 in the notice soliciting such bid. Acceptance of a bid by the
2110 departments shall be based on standard specifications adopted by the
2111 departments. The Department of Social Services may accept gifts,
2112 donations, bequests, grants or funds from public or private agencies
2113 for any or all of the purposes of this section.

2114 (c) On July 1, 2008, and annually thereafter, the Commissioner of
2115 Social Services shall report, in accordance with section 11-4a of the
2116 general statutes, to the joint standing committees of the General
2117 Assembly having cognizance of matters relating to human services,
2118 public health and appropriations and the budgets of state agencies on
2119 the status of the program established pursuant to this section.

2120 Sec. 36. (NEW) (*Effective July 1, 2007*) To the extent permitted by
2121 federal law, any employer in the state that offers health care benefits to
2122 its employees shall offer benefits or premium contributions that are
2123 equivalent in value to all such employees regardless of any differential
2124 in the amount of compensation paid to such employees, except that
2125 such employer may offer employees with a lower amount of
2126 compensation a more comprehensive health care benefit plan or a
2127 higher level of employer premium contribution than that offered to
2128 employees receiving a higher amount of compensation.

2129 Sec. 37. (NEW) (*Effective July 1, 2007*) Any employer that provides

2130 health insurance benefits to its employees for which any portion of the
2131 premiums are deducted from the employees' pay shall offer such
2132 employees the opportunity to have such portion excluded from their
2133 gross income for state or federal income tax purposes, except as
2134 required under Section 125 of the Internal Revenue Code of 1986, or
2135 any subsequent corresponding internal revenue code of the United
2136 States, as from time to time amended.

2137 Sec. 38. (NEW) (*Effective January 1, 2009, and applicable to income years*
2138 *commencing on or after January 1, 2009*) (a) For purposes of this section:

2139 (1) "Employer" means any person, firm, business, educational
2140 institution, nonprofit agency, corporation, limited liability company or
2141 any other entity which, on at least fifty per cent of its working days
2142 during the preceding twelve months, (A) employed ten or fewer
2143 employees, the majority of whom were employed within the state of
2144 Connecticut, (B) employed eleven to fifty employees, the majority of
2145 whom were employed within the state of Connecticut, of whom at
2146 least thirty per cent were paid wages by the employer equal to or less
2147 than three hundred per cent of the federal poverty level, or (C)
2148 employed more than fifty employees, the majority of whom were
2149 employed within the state of Connecticut, of whom at least seventy-
2150 five per cent were paid wages by the employer equal to or less than
2151 one hundred eighty-five per cent of the federal poverty level;

2152 (2) "Full-time employee" means any person employed by an
2153 employer for thirty hours or more a week in a full-time position; and

2154 (3) "Part-time employee" means any person employed by an
2155 employer for less than thirty hours a week in a part-time position.

2156 (b) There is established a tax credit program to assist employers
2157 with providing health insurance to their employees to achieve the goal
2158 of ensuring greater access to health insurance for residents of this state.
2159 Any employer that elects to claim a tax credit pursuant to this section
2160 shall submit to the Connecticut Connector a copy of such employer's
2161 health insurance plan, documentation of employees' wages and proof

2162 of its premium contributions. If the Connecticut Connector certifies
2163 that such plan meets or exceeds the actuarial value for the affordable
2164 health care plan established pursuant to section 2 of this act, the
2165 Connecticut Connector shall issue a certificate indicating such fact.

2166 (c) (1) For income years commencing on or after January 1, 2009,
2167 there shall be allowed a credit against the tax imposed under chapters
2168 208 and 229 of the general statutes on any employer's liability for either
2169 tax, provided such employer (A) has obtained a certificate from the
2170 Connecticut Connector in accordance with this section, and (B) pays at
2171 least seventy per cent of the cost of an employee's health care benefits
2172 and fifty per cent of the cost of dependents' health care benefits for
2173 full-time employees.

2174 (2) For employers offering such coverage to all full-time employees
2175 but not to all part-time employees, the credit shall be in an amount
2176 equal to twenty per cent of the cost of providing health care benefits,
2177 provided such amount shall not exceed eight hundred dollars per
2178 employee per year in the case of a policy covering an individual
2179 employee, one thousand six hundred dollars per employee per year in
2180 the case of a policy covering an employee and only one other
2181 individual, or two thousand four hundred dollars per employee per
2182 year in the case of a policy covering an employee and the family of
2183 such employee.

2184 (3) For employers offering such coverage to all full-time and part-
2185 time employees, the credit shall be in an amount equal to thirty per
2186 cent of the cost of providing health care benefits, provided such
2187 amount shall not exceed one thousand two hundred dollars per
2188 employee per year in the case of a policy covering an individual
2189 employee, two thousand four hundred dollars per employee per year
2190 in the case of a policy covering an employee and only one other
2191 individual, or three thousand six hundred dollars per employee per
2192 year in the case of a policy covering an employee and the family of
2193 such employee.

2194 (4) In the event the employer owes less than the value of the credit
2195 allowed under this subsection, the employer shall be entitled to a
2196 refund from the state in an amount equal to the amount of the unused
2197 credit.

2198 (d) An employer qualifying under subsection (c) of this section that
2199 is a limited liability company, limited liability partnership, limited
2200 partnership or S corporation, as defined in section 12-284b of the
2201 general statutes, may distribute a credit to its members and such
2202 members shall be eligible to use such credit against the tax imposed
2203 under chapter 229 of the general statutes. The total credit that may be
2204 distributed shall not be greater than the following:

2205 (1) For employers offering such coverage to all full-time employees
2206 but not part-time employees, the credit shall be in an amount equal to
2207 twenty per cent of the cost of providing health benefits, provided such
2208 amount shall not exceed eight hundred dollars per employee per year
2209 in the case of a policy covering an individual employee, one thousand
2210 six hundred dollars per employee per year in the case of a policy
2211 covering an employee and only one other individual, or two thousand
2212 four hundred dollars per employee per year in the case of a policy
2213 covering the employee and the family of such employee.

2214 (2) For employers offering such coverage to all full-time and part-
2215 time employees, the credit shall be in an amount equal to thirty per
2216 cent of the cost of providing health benefits, provided such amount
2217 shall not exceed one thousand two hundred dollars per employee per
2218 year in the case of a policy covering an individual employee, two
2219 thousand four hundred dollars per employee per year in the case of a
2220 policy covering an employee and only one other individual, or three
2221 thousand six hundred dollars per employee per year in the case of a
2222 policy covering an employee and the family of such employee.

2223 (e) In the event the individual claiming a credit under this section
2224 owes less than the value of the credit allowed under this section, the
2225 individual shall be entitled to a refund from the state in an amount

2226 equal to the amount of the unused credit.

2227 (f) The dollar amount of the credits in subsections (c) and (d) of this
2228 section shall be annually indexed to the consumer price index for
2229 medical care.

2230 Sec. 39. Subsection (a) of section 12-202a of the general statutes is
2231 repealed and the following is substituted in lieu thereof (*Effective*
2232 *January 1, 2008*):

2233 (a) (1) Each health care center, as defined in section 38a-175, that is
2234 governed by sections 38a-175 to 38a-192, inclusive, shall pay a tax to
2235 the Commissioner of Revenue Services for the calendar year
2236 commencing on January 1, 1995, and [annually thereafter] prior to the
2237 calendar year commencing on January 1, 2008, at the rate of one and
2238 three-quarters per cent of the total net direct subscriber charges
2239 received by such health care center during each such calendar year on
2240 any new or renewal contract or policy approved by the Insurance
2241 Commissioner under section 38a-183. Such payment shall be in
2242 addition to any other payment required under section 38a-48.

2243 (2) Each health care center, as defined in section 38a-175, that is
2244 governed by sections 38a-175 to 38a-192, inclusive, shall pay a tax to
2245 the Commissioner of Revenue Services for the calendar year
2246 commencing on January 1, 2008, and annually thereafter, at the rate of
2247 one and one-half per cent of the total net direct subscriber charges
2248 received by such health care center during each such calendar year on
2249 any new or renewal contract or policy approved by the Insurance
2250 Commissioner under section 38a-183. Such payment shall be in
2251 addition to any other payment required under section 38a-48.

2252 Sec. 40. Section 12-296 of the general statutes is repealed and the
2253 following is substituted in lieu thereof (*Effective October 1, 2007, and*
2254 *applicable to sales occurring on or after October 1, 2007*):

2255 A tax is imposed on all cigarettes held in this state by any person for
2256 sale, said tax to be at the rate of [seventy-five] eighty-two and one-half

2257 mills for each cigarette and the payment thereof shall be for the
2258 account of the purchaser or consumer of such cigarettes and shall be
2259 evidenced by the affixing of stamps to the packages containing the
2260 cigarettes as provided in this chapter.

2261 Sec. 41. Section 12-316 of the general statutes is repealed and the
2262 following is substituted in lieu thereof (*Effective October 1, 2007, and*
2263 *applicable to the storage or use of unstamped cigarettes occurring on or after*
2264 *October 1, 2007*):

2265 A tax is hereby imposed at the rate of [seventy-five] eighty-two and
2266 one-half mills for each cigarette upon the storage or use within this
2267 state of any unstamped cigarettes in the possession of any person other
2268 than a licensed distributor or dealer, or a carrier for transit from
2269 without this state to a licensed distributor or dealer within this state.
2270 Any person, including distributors, dealers, carriers, warehousemen
2271 and consumers, last having possession of unstamped cigarettes in this
2272 state shall be liable for the tax on such cigarettes if such cigarettes are
2273 unaccounted for in transit, storage or otherwise, and in such event a
2274 presumption shall exist for the purpose of taxation that such cigarettes
2275 were used and consumed in Connecticut.

2276 Sec. 42. (NEW) (*Effective October 1, 2007*) (a) An excise tax is hereby
2277 imposed upon each distributor and each dealer, as each are defined in
2278 section 12-285 of the general statutes and licensed pursuant to chapter
2279 214 of the general statutes, in the amount of twenty-four and one-half
2280 mills per cigarette, as defined in said section 12-285, in such
2281 distributor's or such dealer's inventory as of the close of business on
2282 September 30, 2007, or, if the business closes after eleven fifty-nine
2283 o'clock p.m. on such date, at eleven fifty-nine o'clock p.m. on such
2284 date.

2285 (b) Each such licensed distributor or dealer shall, not later than
2286 November 15, 2007, file with the Commissioner of Revenue Services,
2287 on forms prescribed by said commissioner, a report that shows the
2288 number of cigarettes in inventory as of the close of business on

2289 September 30, 2007, or, if the business closes after eleven fifty-nine
2290 o'clock p.m. on such date, at eleven fifty-nine o'clock p.m. on such
2291 date, upon which inventory the tax under subsection (a) of this section
2292 shall be imposed. The tax shall be due and payable on the due date of
2293 such report. If any distributor or dealer required to file a report
2294 pursuant to this section fails to file such report on or before November
2295 15, 2007, the commissioner shall make an estimate of the number of
2296 cigarettes in such distributor's or dealer's inventory as of the close of
2297 business on September 30, 2007, based upon any information that is in
2298 the commissioner's possession or that may come into the
2299 commissioner's possession. The provisions of chapter 214 of the
2300 general statutes pertaining to failure to file returns, examination of
2301 returns by the commissioner, the issuance of deficiency assessments or
2302 assessments where no return has been filed, the collection of tax, the
2303 imposition of penalties and the accrual of interest shall apply to the
2304 distributors and dealers required to pay the tax imposed under this
2305 section. Failure of any distributor or dealer to file such report when
2306 due shall be sufficient reason to revoke such distributor's or dealer's
2307 license under the provisions of said chapter 214 and to revoke any
2308 other state license or permit held by such distributor or dealer.

2309 Sec. 43. Subdivision (37) of subsection (a) of section 12-407 of the
2310 general statutes is repealed and the following is substituted in lieu
2311 thereof (*Effective January 1, 2008, and applicable to sales occurring on and*
2312 *after January 1, 2008*):

2313 (37) "Services" for purposes of subdivision (2) of this subsection,
2314 means:

2315 (A) Computer and data processing services, including, but not
2316 limited to, time, programming, code writing, modification of existing
2317 programs, feasibility studies and installation and implementation of
2318 software programs and systems even where such services are rendered
2319 in connection with the development, creation or production of canned
2320 or custom software or the license of custom software, and exclusive of
2321 services rendered in connection with the creation, development

2322 hosting or maintenance of all or part of a web site which is part of the
2323 graphical, hypertext portion of the Internet, commonly referred to as
2324 the World Wide Web;

2325 (B) Credit information and reporting services;

2326 (C) Services by employment agencies and agencies providing
2327 personnel services;

2328 (D) Private investigation, protection, patrol work, watchman and
2329 armored car services, exclusive of (i) services of off-duty police officers
2330 and off-duty firefighters, and (ii) coin and currency services provided
2331 to a financial services company by or through another financial
2332 services company. For purposes of this subparagraph, "financial
2333 services company" has the same meaning as provided under
2334 subparagraphs (A) to (H), inclusive, of subdivision (6) of subsection (a)
2335 of section 12-218b;

2336 (E) Painting and lettering services;

2337 (F) Photographic studio services;

2338 (G) Telephone answering services;

2339 (H) Stenographic services;

2340 (I) Services to industrial, commercial or income-producing real
2341 property, including, but not limited to, such services as management,
2342 electrical, plumbing, painting and carpentry and excluding any such
2343 services rendered in the voluntary evaluation, prevention, treatment,
2344 containment or removal of hazardous waste, as defined in section
2345 22a-115, or other contaminants of air, water or soil, provided
2346 income-producing property shall not include property used
2347 exclusively for residential purposes in which the owner resides and
2348 which contains no more than three dwelling units, or a housing facility
2349 for low and moderate income families and persons owned or operated
2350 by a nonprofit housing organization, as defined in subdivision (29) of
2351 section 12-412;

2352 (J) Business analysis, management, management consulting and
2353 public relations services, excluding (i) any environmental consulting
2354 services, (ii) any training services provided by an institution of higher
2355 education licensed or accredited by the Board of Governors of Higher
2356 Education pursuant to section 10a-34, and (iii) on and after January 1,
2357 1994, any business analysis, management, management consulting and
2358 public relations services when such services are rendered in connection
2359 with an aircraft leased or owned by a certificated air carrier or in
2360 connection with an aircraft which has a maximum certificated take-off
2361 weight of six thousand pounds or more;

2362 (K) Services providing "piped-in" music to business or professional
2363 establishments;

2364 (L) Flight instruction and chartering services by a certificated air
2365 carrier on an aircraft, the use of which for such purposes, but for the
2366 provisions of subdivision (4) of section 12-410 and subdivision (12) of
2367 section 12-411, would be deemed a retail sale and a taxable storage or
2368 use, respectively, of such aircraft by such carrier;

2369 (M) Motor vehicle repair services, including any type of repair,
2370 painting or replacement related to the body or any of the operating
2371 parts of a motor vehicle;

2372 (N) Motor vehicle parking, including the provision of space, other
2373 than metered space, in a lot having thirty or more spaces, excluding (i)
2374 space in a seasonal parking lot provided by a person who is exempt
2375 from taxation under this chapter pursuant to subdivision (1), (5) or (8)
2376 of section 12-412, (ii) space in a parking lot owned or leased under the
2377 terms of a lease of not less than ten years' duration and operated by an
2378 employer for the exclusive use of its employees, (iii) valet parking
2379 provided at any airport, and (iv) space in municipally-operated
2380 railroad parking facilities in municipalities located within an area of
2381 the state designated as a severe nonattainment area for ozone under
2382 the federal Clean Air Act or space in a railroad parking facility in a
2383 municipality located within an area of the state designated as a severe

2384 nonattainment area for ozone under the federal Clean Air Act owned
2385 or operated by the state on or after April 1, 2000;

2386 (O) Radio or television repair services;

2387 (P) Furniture reupholstering and repair services;

2388 (Q) Repair services to any electrical or electronic device, including,
2389 but not limited to, equipment used for purposes of refrigeration or
2390 air-conditioning;

2391 (R) Lobbying or consulting services for purposes of representing the
2392 interests of a client in relation to the functions of any governmental
2393 entity or instrumentality;

2394 (S) Services of the agent of any person in relation to the sale of any
2395 item of tangible personal property for such person, exclusive of the
2396 services of a consignee selling works of art, as defined in subsection (b)
2397 of section 12-376c, or articles of clothing or footwear intended to be
2398 worn on or about the human body other than (i) any special clothing
2399 or footwear primarily designed for athletic activity or protective use
2400 and which is not normally worn except when used for the athletic
2401 activity or protective use for which it was designed, and (ii) jewelry,
2402 handbags, luggage, umbrellas, wallets, watches and similar items
2403 carried on or about the human body but not worn on the body in the
2404 manner characteristic of clothing intended for exemption under
2405 subdivision (47) of section 12-412, under consignment, exclusive of
2406 services provided by an auctioneer;

2407 (T) Locksmith services;

2408 (U) Advertising or public relations services, including layout, art
2409 direction, graphic design, mechanical preparation or production
2410 supervision, not related to the development of media advertising or
2411 cooperative direct mail advertising;

2412 (V) Landscaping and horticulture services;

- 2413 (W) Window cleaning services;
- 2414 (X) Maintenance services;
- 2415 (Y) Janitorial services;
- 2416 (Z) Exterminating services;
- 2417 (AA) Swimming pool cleaning and maintenance services;
- 2418 (BB) Miscellaneous personal services included in industry group 729
2419 in the Standard Industrial Classification Manual, United States Office
2420 of Management and Budget, 1987 edition, or U.S. industry 532220,
2421 812191, 812199 or 812990 in the North American Industrial
2422 Classification System United States Manual, United States Office of
2423 Management and Budget, 1997 edition, exclusive of (i) services
2424 rendered by massage therapists licensed pursuant to chapter 384a, and
2425 (ii) services rendered by an electrologist licensed pursuant to chapter
2426 388;
- 2427 (CC) Any repair or maintenance service to any item of tangible
2428 personal property including any contract of warranty or service related
2429 to any such item;
- 2430 (DD) Business analysis, management or managing consulting
2431 services rendered by a general partner, or an affiliate thereof, to a
2432 limited partnership, provided (i) the general partner, or an affiliate
2433 thereof, is compensated for the rendition of such services other than
2434 through a distributive share of partnership profits or an annual
2435 percentage of partnership capital or assets established in the limited
2436 partnership's offering statement, and (ii) the general partner, or an
2437 affiliate thereof, offers such services to others, including any other
2438 partnership. As used in this subparagraph "an affiliate of a general
2439 partner" means an entity which is directly or indirectly owned fifty per
2440 cent or more in common with a general partner;
- 2441 (EE) Notwithstanding the provisions of section 12-412, except
2442 subdivision (87) of said section 12-412, patient care services, as defined

2443 in subdivision (29) of this subsection by a hospital, except that "sale"
2444 and "selling" does not include such patient care services for which
2445 payment is received by the hospital during the period commencing
2446 July 1, 2001, and ending June 30, 2003;

2447 [(FF) Health and athletic club services, exclusive of (i) any such
2448 services provided without any additional charge which are included in
2449 any dues or initiation fees paid to any such club, which dues or fees
2450 are subject to tax under section 12-543, (ii) any such services provided
2451 by a municipality or an organization that is described in Section 501(c)
2452 of the Internal Revenue Code of 1986, or any subsequent
2453 corresponding internal revenue code of the United States, as from time
2454 to time amended, and (iii) yoga instruction provided at a yoga studio.]

2455 Sec. 44. (*Effective July 1, 2007*) Notwithstanding the provisions of
2456 section 4-28e of the general statutes, the sum remaining in the Tobacco
2457 and Health Trust Fund shall be transferred from said fund to the
2458 General Fund, of which twenty million dollars shall be used by the
2459 Department of Public Health for the Smoke-Free Connecticut program.

2460 Sec. 45. (*Effective July 1, 2007*) The sum of one million six hundred
2461 thousand dollars is appropriated to the Department of Public Health,
2462 from the General Fund, for the fiscal year ending June 30, 2008, for the
2463 purpose of providing grants to be awarded on July 1, 2008, in the
2464 amount of two hundred thousand dollars to eight different groups
2465 representing the interests of Connecticut employers. Such grants shall
2466 be used to train employers to effectively educate employees
2467 concerning the financial and health benefits of making lifestyle choices
2468 that promote good health, including maintaining a healthy weight and
2469 regularly exercising.

2470 Sec. 46. (*Effective July 1, 2007*) An amount is appropriated to the
2471 Department of Social Services, from the General Fund, for the fiscal
2472 year ending June 30, 2008, for the purposes of section 32 of this act.

2473 Sec. 47. (*Effective July 1, 2007*) The sum of five hundred thousand
2474 dollars is appropriated to the Department of Social Services, from the

2475 General Fund, for the fiscal year ending June 30, 2008, for the purpose
2476 of providing grants to community-based organizations under
2477 subsection (e) of section 17b-297 of the general statutes, as amended by
2478 this act.

2479 Sec. 48. (*Effective July 1, 2007*) The sum of one million dollars is
2480 appropriated to the Department of Social Services, from the General
2481 Fund, for the fiscal year ending June 30, 2008, for the purpose of
2482 obtaining consultant services to assist the department in the
2483 implementation of sections 25 and 35 of this act.

2484 Sec. 49. (*Effective July 1, 2007*) The sum of five hundred thousand
2485 dollars is appropriated to the Office of Health Care Access, from the
2486 General Fund, for the fiscal year ending June 30, 2008, for the purposes
2487 of the Health Care Reform Commission established under section 2 of
2488 this act.

2489 Sec. 50. (*Effective July 1, 2007*) The sum of five hundred thousand
2490 dollars is appropriated to the Office of Health Care Access, from the
2491 General Fund, for the fiscal year ending June 30, 2008, for the purpose
2492 of providing one-time start-up funds for the establishment of the
2493 Connecticut Health Quality Partnership pursuant to section 19 of this
2494 act, which shall be contingent upon the partnership obtaining a
2495 commitment by six or more members to contribute dues sufficient to
2496 assure the financial viability of the organization.

2497 Sec. 51. (*Effective July 1, 2007*) The sum of two hundred thousand
2498 dollars is appropriated to the Office of Health Care Access, from the
2499 General Fund, for the fiscal year ending June 30, 2008, for the purpose
2500 of conducting the study and survey as required by section 20 of this
2501 act.

2502 Sec. 52. (*Effective July 1, 2007*) An amount is appropriated to the
2503 Office of Health Care Access, from the General Fund, for the fiscal year
2504 ending June 30, 2008, for the purposes of the subcommittee on Healthy
2505 Lifestyles established under section 18 of this act.

2506 Sec. 53. (*Effective July 1, 2008*) An amount is appropriated to the
 2507 Office of Health Care Access, from the General Fund, for the fiscal year
 2508 ending June 30, 2009, for the purposes of the subcommittee on Healthy
 2509 Lifestyles established under section 18 of this act.

2510 Sec. 54. (*Effective July 1, 2007*) The sum of one million dollars is
 2511 appropriated to the Insurance Department from the General Fund, for
 2512 the fiscal year ending June 30, 2008, for the purpose of providing start-
 2513 up costs for the Connecticut Connector.

2514 Sec. 55. Section 17b-261c of the general statutes is repealed. (*Effective*
 2515 *January 1, 2008*)"

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2007</i>	New section
Sec. 2	<i>July 1, 2007</i>	New section
Sec. 3	<i>July 1, 2007</i>	New section
Sec. 4	<i>March 1, 2009</i>	New section
Sec. 5	<i>January 1, 2009</i>	New section
Sec. 6	<i>March 1, 2009</i>	New section
Sec. 7	<i>October 1, 2007</i>	New section
Sec. 8	<i>October 1, 2008</i>	New section
Sec. 9	<i>October 1, 2008</i>	New section
Sec. 10	<i>January 1, 2008</i>	38a-567
Sec. 11	<i>October 1, 2007</i>	38a-497
Sec. 12	<i>October 1, 2007</i>	New section
Sec. 13	<i>October 1, 2007</i>	38a-554
Sec. 14	<i>October 1, 2007</i>	38a-482
Sec. 15	<i>July 1, 2007</i>	New section
Sec. 16	<i>July 1, 2007</i>	New section
Sec. 17	<i>July 1, 2007</i>	New section
Sec. 18	<i>January 1, 2008</i>	New section
Sec. 19	<i>July 1, 2007</i>	New section
Sec. 20	<i>October 1, 2007</i>	New section
Sec. 21	<i>October 1, 2007</i>	New section
Sec. 22	<i>July 1, 2007</i>	New section
Sec. 23	<i>July 1, 2007</i>	New section
Sec. 24	<i>July 1, 2007</i>	New section

Sec. 25	<i>July 1, 2007</i>	New section
Sec. 26	<i>July 1, 2007</i>	New section
Sec. 27	<i>July 1, 2007</i>	17b-192
Sec. 28	<i>July 1, 2007</i>	17b-261
Sec. 29	<i>July 1, 2007</i>	17b-277
Sec. 30	<i>July 1, 2007</i>	17b-292
Sec. 31	<i>July 1, 2008</i>	17b-267
Sec. 32	<i>July 1, 2007</i>	New section
Sec. 33	<i>July 1, 2007</i>	17b-297
Sec. 34	<i>July 1, 2007</i>	17b-297b
Sec. 35	<i>July 1, 2007</i>	New section
Sec. 36	<i>July 1, 2007</i>	New section
Sec. 37	<i>July 1, 2007</i>	New section
Sec. 38	<i>January 1, 2009, and applicable to income years commencing on or after January 1, 2009</i>	New section
Sec. 39	<i>January 1, 2008</i>	12-202a(a)
Sec. 40	<i>October 1, 2007, and applicable to sales occurring on or after October 1, 2007</i>	12-296
Sec. 41	<i>October 1, 2007, and applicable to the storage or use of unstamped cigarettes occurring on or after October 1, 2007</i>	12-316
Sec. 42	<i>October 1, 2007</i>	New section
Sec. 43	<i>January 1, 2008, and applicable to sales occurring on and after January 1, 2008</i>	12-407(a)(37)
Sec. 44	<i>July 1, 2007</i>	New section
Sec. 45	<i>July 1, 2007</i>	New section
Sec. 46	<i>July 1, 2007</i>	New section
Sec. 47	<i>July 1, 2007</i>	New section
Sec. 48	<i>July 1, 2007</i>	New section
Sec. 49	<i>July 1, 2007</i>	New section
Sec. 50	<i>July 1, 2007</i>	New section
Sec. 51	<i>July 1, 2007</i>	New section
Sec. 52	<i>July 1, 2007</i>	New section

Sec. 53	<i>July 1, 2008</i>	New section
Sec. 54	<i>July 1, 2007</i>	New section
Sec. 55	<i>January 1, 2008</i>	Repealer section