



General Assembly

February Session, 2008

**Raised Bill No. 5721**

LCO No. 2513

\*02513\_\_\_\_\_INS\*

Referred to Committee on Insurance and Real Estate

Introduced by:  
(INS)

**AN ACT ESTABLISHING THE CONNECTICUT HEALTHY STEPS PROGRAM.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective July 1, 2008*) Sections 1 to 9, inclusive, 11  
2 to 21, inclusive, and 26 to 27, inclusive, of this act, and subsection (a) of  
3 section 17b-192 of the 2008 supplement to the general statutes, section  
4 17b-261 of the 2008 supplement to the general statutes, section 17b-267  
5 of the general statutes, section 17b-292 of the 2008 supplement to the  
6 general statutes, and section 38a-567 of the general statutes, as  
7 amended by this act, shall be known as the Connecticut Healthy Steps  
8 program.

9 Sec. 2. (NEW) (*Effective July 1, 2008*) (a) There is established a  
10 permanent Health Care Reform Commission, which shall be an  
11 independent, nonprofit body within the Office of Health Care Access  
12 for administrative purposes only. The commission shall consist of the  
13 Comptroller, the Commissioners of Social Services, Public Health and  
14 Health Care Access and the Insurance Commissioner, or their  
15 designees, and nine additional members appointed as follows: One by  
16 the Connecticut Medical Society; one by the Connecticut Hospital

17 Association; one by the Connecticut Association of Health Plans; one  
18 by the Connecticut Business and Industry Association; two from  
19 consumer advocacy organizations, one of whom shall be appointed by  
20 the president pro tempore of the Senate and one of whom shall be  
21 appointed by the speaker of the House of Representatives; and three  
22 by the Governor, one of whom shall be an owner of a Connecticut  
23 business with fifty or fewer employees in the state, one of whom shall  
24 be an owner, senior manager or human resources director of a  
25 Connecticut business with more than fifty employees in the state, and  
26 one of whom shall be a senior manager or human resources director of  
27 a labor union that offers a Taft-Hartley plan.

28 (b) Notwithstanding the provisions of subsection (c) of section 4-9a  
29 of the general statutes, the nine additional appointed members of the  
30 commission shall serve for staggered terms. The initial members  
31 selected shall serve as follows from the date of appointment: (1) The  
32 members appointed by the Connecticut Hospital Association, the  
33 Connecticut Association of Health Plans and the Connecticut Business  
34 and Industry Association shall serve for three years; (2) the members  
35 appointed by the Connecticut Medical Society, the president pro  
36 tempore of the Senate and the speaker of the House of Representatives  
37 shall serve for two years; and (3) the members appointed by the  
38 Governor shall serve for one year. Following the expiration of such  
39 initial terms, each subsequent appointee shall serve for a term of three  
40 years. Any vacancy shall be filled by the appointing authority for the  
41 unexpired portion of the term of the member replaced. Members may  
42 be reappointed to serve consecutive terms. The members shall serve  
43 without compensation for their services but shall be reimbursed for  
44 their expenses.

45 (c) The commission shall:

46 (1) (A) Notwithstanding section 38a-553 of the general statutes, not  
47 later than April 1, 2009, design health benefit plans that shall be known  
48 as affordable health care plans that meet the requirements of section 4

49 of this act and are approved by the Insurance Commissioner, (B) not  
50 later than January 1, 2010, make such plans available for sale, and if  
51 any employer purchases such plan for its employees through the  
52 Connecticut Connector, as defined in section 3 of this act, or any other  
53 plan through the Connecticut Connector for its employees that is at  
54 least equivalent to the type and level of benefits of affordable health  
55 care plans, such employer shall qualify for a tax credit pursuant to  
56 section 27 of this act, and (C) adopt rules for the collection of fees in  
57 accordance with subdivision (4) of subsection (d) of section 3 of this  
58 act;

59 (2) Not later than October 1, 2010, submit a report to the joint  
60 standing committee of the General Assembly having cognizance of  
61 matters relating to insurance, in accordance with section 11-4a of the  
62 general statutes, that identifies the effect of health insurance mandates  
63 under chapter 700c of the general statutes on health care premiums  
64 paid by private sector employers;

65 (3) Explore incentive options to encourage individuals to use health  
66 insurance responsibly;

67 (4) Determine the fee that insurance producers shall be paid for  
68 making referrals for affordable health care plans to the Connecticut  
69 Connector, as a percentage of the premium;

70 (5) Establish a subcommittee on healthy lifestyles under section 13  
71 of this act;

72 (6) Not later than July 1, 2009, establish the Connecticut Health  
73 Quality Partnership under section 14 of this act;

74 (7) Perform the duties as required under section 15 of this act;

75 (8) Not later than April 1, 2009, develop a plan for (A) the collection  
76 of premium from individuals and employers purchasing coverage  
77 through the Connecticut Connector, (B) imposition of penalties for late  
78 premium payments, as provided in section 38a-483 of the general

79 statutes, and (C) termination of coverage for nonpayment of premium;  
80 and

81 (9) Not later than January 1, 2010, and annually thereafter, make  
82 recommendations to the General Assembly concerning the  
83 implementation of the Connecticut Healthy Steps program and  
84 improvements to the health care system, including cost controls.

85 (d) The commission shall meet as often as necessary to complete its  
86 work, but not less than quarterly each year. The commission, within  
87 available appropriations, may hire consultants and staff, who shall not  
88 be hired as employees of the state, to provide assistance with its  
89 responsibilities.

90 (e) For the purposes of sections 2 to 15, inclusive, of this act,  
91 "commission" means the Health Care Reform Commission.

92 Sec. 3. (NEW) (*Effective July 1, 2008*) (a) There is established a  
93 program which shall be known as the "Connecticut Connector", to be  
94 administered in accordance with the provisions of this section by the  
95 Health Reinsurance Association established in section 38a-556 of the  
96 general statutes, and through which eligible individuals and  
97 employers may purchase affordable health care plans.

98 (b) The Health Reinsurance Association shall administer the  
99 Connecticut Connector in accordance with the provisions of section  
100 38a-556 of the general statutes, as amended by this act.

101 (c) Such association administering the Connecticut Connector shall  
102 meet with the Health Care Reform Commission appointed in section 2  
103 of this act in accordance with a schedule the commission determines to  
104 be appropriate.

105 (d) The Health Reinsurance Association established pursuant to  
106 section 38a-556, as amended by this act, shall perform the following  
107 duties:

108 (1) Screen individual health insurance policy applicants for  
109 eligibility to purchase through the Connecticut Connector;

110 (2) Screen applicants consisting of individuals for eligibility for the  
111 programs established under sections 8 and 9 of this act;

112 (3) Make payments to agents for referrals of small employers and  
113 individuals that qualify for and purchase affordable health care plans;

114 (4) Collect fees based on total covered lives from all insurers and  
115 health care centers licensed in the state to sell health insurance policies  
116 or group health insurance plans, excluding the Medicaid managed care  
117 health plans, in accordance with rules adopted by the commission, to  
118 support the costs of administration as defined by this subsection and  
119 any additional functions deemed appropriate by the commission.  
120 Covered lives shall include, but not be limited to, all persons who are:  
121 (A) Covered under an individual health insurance policy issued or  
122 delivered in Connecticut; (B) covered under a group health insurance  
123 policy issued or delivered in Connecticut; (C) covered under a group  
124 health insurance policy evidenced by a certificate of insurance issued  
125 or delivered in Connecticut; or (D) protected in part by a group stop  
126 loss insurance policy where the policy or certificate of coverage is  
127 issued or delivered in Connecticut and where coverage is purchased  
128 by a group health insurance plan subject to the Employee Retirement  
129 Income Security Act of 1974 (P.L. 93-406) (ERISA);

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

133 (6) Market the health plans available through the Connecticut  
134 Connector to potential purchasers of the health plans including, but  
135 not limited to, through the use of advertising, public information  
136 campaigns and outreach through the Medicaid and other publicly  
137 funded health programs, the chambers of commerce or other trade or  
138 professional associations or health care providers;

139 (7) Provide information to applicants who may be eligible for the  
140 Medicaid program or the HUSKY Plan, Part A and Part B, as to how  
141 and where to apply for such programs;

142 (8) Determine employer eligibility for a tax credit and the amount of  
143 such tax credit in accordance with section 27 of this act and provide  
144 certification for use in claiming such tax credit from the Department of  
145 Revenue Services;

146 (9) Receive moneys from the Comptroller and make payments to  
147 eligible individuals and employers in accordance with sections 8 and 9  
148 of this act;

149 (10) Not later than July 1, 2010, and annually thereafter, provide  
150 data and reports to the commission and the General Assembly that  
151 shall include, but not be limited to, (A) the number and demographics  
152 of previously uninsured persons covered through the Connecticut  
153 Connector by type of policy, (B) the per capita administrative costs of  
154 the Connecticut Connector, (C) any recommendations for improving  
155 service, health insurance policy offerings and costs, and (D) any other  
156 information as required by the commission.

157 (11) For individual insurance: (A) Assisted by the commission,  
158 notify insurers of the opportunity to make affordable health care plans  
159 available for sale through the Connecticut Connector and process  
160 applications; (B) publish easy to understand materials for prospective  
161 purchasers, comparing the costs and benefits of all plans to assist in  
162 plan selection; (C) assist applicants to understand the benefits offered  
163 under the plans and assist in selecting a plan that reflects the need and  
164 income of the applicant, except that such assistance shall not be  
165 deemed to require an insurance agent license; (D) work with the  
166 insurers selling products through the Connecticut Connector to  
167 develop and adopt a uniform tool approved by the Insurance  
168 Commissioner for collecting necessary applicant or enrollee data for  
169 any appropriate underwriting, enrollment and other purposes; (E)  
170 collect premium contributions from employers and individuals, as well

171 as subsidies from the state, and remit them to enrollees' health plans;  
172 (F) notify insureds when their premiums are late and disenroll them or  
173 levy late penalties in accordance with the provisions of section 38a-483  
174 of the general statutes; and (G) provide information regarding Health  
175 Reinsurance Association benefits to applicants who are denied  
176 coverage due to underwriting concerns;

177 (12) For small employer plans: (A) Solicit and select two or more  
178 third party administrators to administer affordable health care plans;  
179 (B) file and obtain Insurance Department approval for affordable  
180 health care plans for small employers; (C) perform or contract for all  
181 functions necessary to offer and service affordable health care plans,  
182 including premium collection, actuarial work to develop rates,  
183 issuance of payment to agents, development of application forms,  
184 enrollment and obtaining capital for reserves and to cover losses; and  
185 (D) price the affordable health care plans to break even each year, with  
186 surpluses deposited into a separate, nonlapsing account within the  
187 General Fund. The Insurance Commissioner shall use the account to  
188 cover future losses or to reduce future premiums, as deemed  
189 appropriate by the commission, and losses shall be funded through  
190 borrowed funds paid back from future premium increases.

191 Sec. 4. (NEW) (*Effective March 1, 2010*) (a) The Health Reinsurance  
192 association established pursuant to section 38a-556, as amended by this  
193 act, that administers the Connecticut Connector, as defined in section 3  
194 of this act, shall make available affordable health care plans for  
195 individuals and employers established in accordance with standards  
196 set forth by the commission.

197 (b) Such plans shall include: (1) Minimum benefits as follows: (A)  
198 Coverage of physician, clinic, ambulatory surgery, laboratory and  
199 diagnostic service, in-patient and out-patient hospital care and  
200 prescription drugs that are medically necessary, as defined in  
201 subsection (a) of section 38a-482a of the general statutes, for physical  
202 or mental health; (B) out-of-pocket costs including, but not limited to,

203 copayments, deductibles and coinsurance that shall reflect the  
204 following family income brackets: (i) Family income that is less than  
205 two hundred per cent of the federal poverty level, (ii) family income  
206 that is equal to or greater than two hundred per cent but less than  
207 three hundred per cent of the federal poverty level, (iii) family income  
208 that is greater than three hundred per cent but less than four hundred  
209 per cent of the federal poverty level, and (iv) family income that is  
210 greater than four hundred per cent of the federal poverty level; (C) no  
211 deductible for well-child visits, prenatal care and the first two  
212 physician visits annually; (D) a lifetime benefits maximum in an  
213 amount not less than five hundred thousand dollars, contingent upon  
214 availability of an excess cost reinsurance program established by the  
215 Department of Social Services as provided in section 18 of this act. In  
216 the event such excess cost reinsurance program is not available, the  
217 lifetime benefits maximum shall be in an amount not less than one  
218 million dollars.

219 (c) The affordable health care plans shall be exempt from the  
220 minimum coverages or benefits set forth in chapter 700c of the general  
221 statutes. The premium for such plans shall not exceed two hundred  
222 dollars per eligible enrollee or dependent per month on average,  
223 adjusted for inflation in average health insurance premiums in the  
224 state as determined annually by the Insurance Department. If the  
225 Health Reinsurance Association cannot structure an employer plan for  
226 this amount or if no carriers are willing to sell a plan for this amount,  
227 the commission shall adjust the benefit design.

228 (d) Individual plans offered for sale through the Connecticut  
229 Connector shall be specifically priced to reflect the reduced  
230 administrative costs to the insurer resulting from the performance of  
231 administrative duties by the Connecticut Connector.

232 (e) Such individual plans shall have a minimum loss ratio of not less  
233 than seventy-five per cent for individual health care plans over any  
234 three-year moving average period, provided "loss", for the purposes of

235 such term, shall not include administrative activities including, but not  
236 limited to, enrollment, marketing, premium collection, claims  
237 adjudication, member services and profit.

238 (f) With respect to an applicant for an individual affordable health  
239 care plan with an identified preexisting condition, an insurer or health  
240 care center offering individual insurance coverage through the  
241 Connecticut Connector may: (1) Deny coverage to such applicant; (2)  
242 impose an additional deductible of not more than five hundred dollars  
243 for such preexisting condition; (3) impose a limitation in accordance  
244 with the provisions of section 38a-476 of the 2008 supplement to the  
245 general statutes; (4) obtain reinsurance coverage for such identified  
246 preexisting condition through the Connecticut Individual Health  
247 Reinsurance Pool established under section 6 of this act. The pool  
248 reimbursement relative to such preexisting condition shall be limited  
249 to the actual paid reinsured benefits in excess of five thousand dollars  
250 but not greater than seventy-five thousand dollars for the first twelve  
251 months of the term of the individual affordable health care plan  
252 reinsured pursuant to this subsection. The board of directors of said  
253 pool shall determine the reinsurance premium rates in accordance  
254 with the provisions of section 38a-570 of the general statutes. Such  
255 amounts shall be annually indexed to the consumer price index for  
256 medical care; or (5) impose an exclusionary rider that permanently  
257 excludes a narrowly defined condition from coverage.

258 (g) Each individual affordable health care plan offered through the  
259 Connecticut Connector shall: (1) Have premium rates established on  
260 the basis of a community rate, adjusted to reflect the individual's age,  
261 gender, not more than two levels of health status, excellent and good,  
262 family composition, county of residence and tobacco use; and (2) shall  
263 be renewable at the option of the policyholder.

264 (h) The affordable health care plans offered by the Connecticut  
265 Connector to small employers shall have premium rates established on  
266 the basis of a community rate in accordance with the provisions of

267 subdivision (5) of section 38a-567 of the general statutes, as amended  
268 by this act.

269 (i) Coverage under each of the affordable health care plans shall be  
270 deemed to be creditable coverage, as defined in 42 USC 300gg(c).

271 (j) Any employer that purchases an affordable health care plan  
272 through the Connecticut Connector may offer its employees only that  
273 plan or may offer such plan as a choice among an array of  
274 comprehensive plans or a high deductible health plan issued with a  
275 health savings account. In the event an employer offers plans in  
276 addition to the affordable health care plan, such employer may offer  
277 the same percentage or dollar contribution for all plans if such  
278 employer allows its employees to select a plan.

279 Sec. 5. (NEW) (*Effective January 1, 2010*) (a) An application by an  
280 individual, who can show proof of residency in the state, to purchase  
281 coverage through the Connecticut Connector, as defined in section 3 of  
282 this act, may be approved in cases in which such individual has no  
283 access to employer-sponsored coverage under which the employer  
284 pays a minimum of fifty per cent of the cost of such coverage for an  
285 individual and his or her dependents and such individual has been  
286 either: (1) Uninsured for a period of at least six months; or (2)  
287 uninsured for a period of less than six months due to the occurrence of  
288 a major life event that has resulted in such uninsured status, including,  
289 but not limited to, (A) loss of coverage through the employer, due to  
290 termination of employment, (B) death of, or abandonment by, a family  
291 member through whom coverage was previously provided, (C) loss of  
292 dependent coverage when the individual's spouse became Medicare  
293 eligible due to age or disability, (D) loss of coverage as a dependent  
294 under any group health insurance policy providing coverage of the  
295 type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section  
296 38a-469 of the general statutes due to age, divorce or other changes in  
297 status, (E) expiration of the coverage periods established by the  
298 Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272)

299 (COBRA), as amended from time to time, (F) extreme economic  
300 hardship on the part of either the employee or the employer, as  
301 determined by the organization that administers the Connecticut  
302 Connector, in accordance with specific measurable criteria defined by  
303 the commission, and (G) any other events that may be specified by the  
304 commission. For purposes of this subsection, "proof of residency"  
305 means evidence of domicile in the state such as voter registration, tax  
306 filings, utility bill or other documentation deemed satisfactory by the  
307 Insurance Commissioner.

308 (b) An application by an employer to purchase coverage through  
309 the Connecticut Connector may be approved if such employer: (1) Has  
310 fifty or fewer employees; (2) has not offered a comprehensive health  
311 insurance plan to any employee for a period of at least six months; (3)  
312 will contribute a minimum of seventy per cent of the cost of the  
313 affordable health care plan for an employee or a minimum of fifty per  
314 cent of the cost of an employee plus dependent coverage under the  
315 least expensive plan available through the Connecticut Connector for  
316 any dependent of such employee; and (4) attests to the Health  
317 Reinsurance Association that at least ninety per cent of the employer's  
318 employees either have coverage through another health care plan or  
319 will enroll in a health care plan through the Connecticut Connector.

320 Sec. 6. (NEW) (*Effective March 1, 2010*) (a) (1) As used in this section:

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

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

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

327 (D) "Individual" means a natural person provided coverage under  
328 an individual health insurance policy that has been approved by the

329 Insurance Department who is deemed to be the policyholder;

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

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

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

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

339 (2) There is established a nonprofit entity which shall be known as  
340 the "Connecticut Individual Health Reinsurance Pool". All insurers  
341 issuing health insurance in this state on and after March 1, 2010, shall  
342 be members of the pool. The board of directors of the Connecticut  
343 Small Employer Health Reinsurance Pool established under section  
344 38a-569 of the general statutes shall administer the pool.

345 (3) Not later than ninety days after the effective date of this section,  
346 the board shall submit to the commissioner a plan of operation and,  
347 thereafter, any amendments thereto necessary or suitable to assure the  
348 fair, reasonable and equitable administration of the pool. The  
349 commissioner shall, after notice and hearing, approve the plan of  
350 operation, provided the commissioner determines it to be suitable to  
351 assure the fair, reasonable and equitable administration of the pool,  
352 and provides for the sharing of pool gains or losses on an equitable  
353 proportionate basis in accordance with the provisions of subsection (d)  
354 of this section. The plan of operation shall become effective upon  
355 approval, in writing, by the commissioner consistent with the date on  
356 which the coverage under this section shall be made available. If the  
357 board fails to submit a suitable plan of operation not later than one  
358 hundred eighty days after the effective date of this section, or at any

359 time thereafter fails to submit suitable amendments to the plan of  
360 operation, the commissioner shall, after notice and hearing, adopt and  
361 promulgate a plan of operation or amendments, as appropriate. The  
362 commissioner shall amend any plan adopted, as necessary, at the time  
363 a plan of operation is submitted by the board and approved by the  
364 commissioner.

365 (4) The plan of operation shall establish procedures for: (A)  
366 Handling and accounting of assets and moneys of the pool, and for an  
367 annual fiscal reporting to the commissioner; (B) selecting an  
368 administrator and setting forth the powers and duties of the  
369 administrator; (C) reinsuring risks in accordance with the provisions of  
370 this section; (D) collecting assessments from all members to provide for  
371 claims reinsured by the pool and for administrative expenses incurred  
372 or estimated to be incurred during the period for which the assessment  
373 is made; and (E) any additional matters at the discretion of the board.

374 (5) The pool shall have the general powers and authority granted  
375 under the laws of Connecticut to insurance companies licensed to  
376 transact health insurance and, in addition thereto, the specific  
377 authority to: (A) Enter into contracts as are necessary or proper to  
378 carry out the provisions and purposes of this section, including the  
379 authority, with the approval of the commissioner, to enter into  
380 contracts with programs of other states for the joint performance of  
381 common functions, or with persons or other organizations for the  
382 performance of administrative functions; (B) sue or be sued, including  
383 taking any legal actions necessary or proper for recovery of any  
384 assessments for, on behalf of or against members; (C) take such legal  
385 action as necessary to avoid the payment of improper claims against  
386 the pool; (D) define the array of health coverage products for which  
387 reinsurance will be provided, and to issue reinsurance policies, in  
388 accordance with the requirements of this section; (E) establish rules,  
389 conditions and procedures pertaining to the reinsurance of members'  
390 risks by the pool; (F) establish appropriate rates, rate schedules, rate  
391 adjustments, rate classifications and any other actuarial functions

392 appropriate to the operation of the pool; (G) assess members in  
393 accordance with the provisions of subsection (e) of this section, and to  
394 make advance interim assessments as may be reasonable and  
395 necessary for organizational and interim operating expenses. Any such  
396 interim assessments shall be credited as offsets against any regular  
397 assessments due following the close of the fiscal year; (H) appoint from  
398 among members appropriate legal, actuarial and other committees as  
399 necessary to provide technical assistance in the operation of the pool,  
400 policy and other contract design, and any other function within the  
401 authority of the pool; and (I) borrow money to effect the purposes of  
402 the pool. Any notes or other evidence of indebtedness of the pool not  
403 in default shall be legal investments for insurers and may be carried as  
404 admitted assets.

405 (b) Any member may reinsure with the pool coverage of an eligible  
406 individual, as defined in the pool's plan of operation, who has an  
407 identified preexisting condition. The pool reimbursement relative to  
408 such preexisting condition shall be limited to the actual paid reinsured  
409 benefits in excess of five thousand dollars but not greater than seventy-  
410 five thousand dollars for the first twelve months of the term of the  
411 individual affordable health care plan reinsured pursuant to this  
412 subsection. The board of directors of said pool shall determine the  
413 reinsurance premium rated in accordance with the provisions of  
414 section 38a-570 of the general statutes. Such amounts shall be annually  
415 indexed to the consumer price index for medical care. Any reinsurance  
416 placed with the pool from the date of the establishment of the pool  
417 regarding such coverage shall be approved by the commissioner. The  
418 commissioner may; adopt regulations, in accordance with chapter 54  
419 of the general statutes, to implement the requirements of this section.

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

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

429 (e) Subject to subsection (c) of this section, (1) following the close of  
430 each fiscal year, the administrator shall determine the net premiums,  
431 the pool expenses of administration and the incurred losses for the  
432 year, taking into account investment income and other appropriate  
433 gains and losses. Health insurance premiums and benefits paid by a  
434 member that are less than an amount determined by the board to  
435 justify the cost of collection shall not be considered for purposes of  
436 determining assessments. For purposes of this subsection, "net  
437 premiums" means health insurance premiums, less administrative  
438 expense allowances.

439 (2) Any net loss for the year shall be recouped by assessments of  
440 members as follows:

441 (A) Assessments shall first be apportioned by the board of directors  
442 of such reinsurance pool among all members in proportion to their  
443 respective shares of the total health insurance premiums earned in this  
444 state from health insurance plans covering individuals during the  
445 calendar year coinciding with or ending during the fiscal year of the  
446 pool, or on any other equitable basis reflecting coverage of individuals  
447 as may be provided in the plan of operations. An assessment shall be  
448 made pursuant to this subparagraph against a health care center,  
449 which is approved by the Secretary of Health and Human Services as a  
450 health maintenance organization pursuant to 42 USC 300e et seq.,  
451 subject to an assessment adjustment formula adopted by the board and  
452 approved by the commissioner for such health care centers which  
453 recognizes the restrictions imposed on such health care centers by  
454 federal law. Such adjustment formula shall be adopted by the board  
455 and approved by the commissioner prior to the first anniversary of the

456 pool's operation.

457 (B) If such net loss is not recouped before assessments totaling five  
458 per cent of such premiums from plans and arrangements covering  
459 eligible individuals have been collected, additional assessments shall  
460 be apportioned by the board among all members in proportion to their  
461 respective shares of the total health insurance premiums earned in this  
462 state from other individual and group plans and arrangements,  
463 exclusive of any individual Medicare supplement policies, as defined  
464 in section 38a-495 of the general statutes, during such calendar year.

465 (C) Notwithstanding the provisions of this subdivision, the  
466 assessments to any one member under subparagraph (A) or (B) of this  
467 subdivision shall not exceed forty per cent of the total assessment  
468 under each subparagraph for the first fiscal year of the pool's operation  
469 and fifty per cent of the total assessment under each subparagraph for  
470 the second fiscal year. Any amounts abated pursuant to this  
471 subparagraph shall be assessed against the other members in a manner  
472 consistent with the basis for assessments set forth in this subdivision.

473 (3) If assessments exceed actual losses and administrative expenses  
474 of the pool, the excess shall be held at interest and used by the board of  
475 directors of such reinsurance pool to offset future losses or to reduce  
476 pool premiums. As used in this subsection, "future losses" includes  
477 reserves for incurred, but not reported, claims.

478 (4) Each member's proportion of participation in the pool shall be  
479 determined annually by the said board of directors based on annual  
480 statements and other reports deemed necessary by the board and filed  
481 by the member with it.

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

484 (6) The said board of directors may defer, in whole or in part, the  
485 assessment of a health care center if, in the opinion of the board: (A)

486 Payment of the assessment would endanger the ability of the health  
487 care center to fulfill its contractual obligations, or (B) in accordance  
488 with standards included in the plan of operation, the health care center  
489 has written, and reinsured in their entirety, a disproportionate number  
490 of individual health care plans offered under section 4 of this act. In  
491 the event an assessment against a health care center is deferred in  
492 whole or in part, the amount by which such assessment is deferred  
493 may be assessed against the other members in a manner consistent  
494 with the basis for assessments set forth in this subsection. The health  
495 care center receiving such deferment shall remain liable to the pool for  
496 the amount deferred. The board may attach appropriate conditions to  
497 any such deferment.

498 (f) (1) Neither the participation in the pool as members, the  
499 establishment of rates, forms or procedures nor any other joint or  
500 collective action required by this section shall be the basis of any legal  
501 action, criminal or civil liability or penalty against the pool or any of its  
502 members.

503 (2) Any person or member made a party to any action, suit or  
504 proceeding because the person or member served on the board of  
505 directors of such reinsurance pool or on a committee or was an officer  
506 or employee of the pool shall be held harmless and be indemnified  
507 against all liability and costs, including the amounts of judgments,  
508 settlements, fines or penalties, and expenses and reasonable attorney's  
509 fees incurred in connection with the action, suit or proceeding. The  
510 indemnification shall not be provided on any matter in which the  
511 person or member is finally adjudged in the action, suit or proceeding  
512 to have committed a breach of duty involving gross negligence,  
513 dishonesty, wilful misfeasance or reckless disregard of the  
514 responsibilities of office. Costs and expenses of the indemnification  
515 shall be prorated and paid for by all members. The commissioner may  
516 retain actuarial consultants necessary to carry out his or her  
517 responsibilities pursuant to this section, and such expenses shall be  
518 paid by the pool established in this section.

519       Sec. 7. (NEW) (*Effective October 1, 2008*) (a) The Connecticut  
520 Connector, as defined in section 3 of this act, shall, not later than thirty  
521 days after receipt of all relevant information provided by an employer,  
522 determine whether to certify that an employer is eligible for a tax  
523 credit pursuant to section 27 of this act.

524       (b) The Connecticut Connector shall provide information to  
525 employers seeking assistance with obtaining certification pursuant to  
526 this section.

527       Sec. 8. (NEW) (*Effective October 1, 2009*) (a) There is established the  
528 health savings account incentive program. To be eligible for payment  
529 pursuant to this section, an individual's family income may not exceed  
530 three hundred per cent of the federal poverty level. The Connecticut  
531 Connector, as defined in section 3 of this act, shall annually contribute  
532 to the health savings account of any individual who has resided in the  
533 state for a period of not less than six months and who has a health  
534 savings account and high deductible health plan pursuant to section  
535 223 of the Internal Revenue Code of 1986, or any subsequent  
536 corresponding internal revenue code of the United States, as from time  
537 to time amended, an amount determined by a sliding scale as follows:

538       (1) For a family income equal to or less than two hundred per cent  
539 of the federal poverty level, five hundred dollars for an individual who  
540 has contributed or received contributions of at least two thousand five  
541 hundred dollars in his or her health savings account in the previous  
542 year, one thousand dollars for a family of two who has contributed or  
543 received contributions of at least three thousand seven hundred fifty  
544 dollars in their health savings account in the previous year, or one  
545 thousand five hundred dollars for a family of three or more who has  
546 contributed or received contributions of at least five thousand dollars  
547 in their health savings account in the previous year;

548       (2) For a family income greater than two hundred per cent but less  
549 than three hundred per cent of the federal poverty level, four hundred  
550 dollars for an individual who has contributed or received

551 contributions of at least two thousand five hundred dollars in his or  
552 her health savings account in the previous year, eight hundred dollars  
553 for a family of two who has contributed or received contributions of at  
554 least three thousand seven hundred fifty dollars in their health savings  
555 account in the previous year, or one thousand two hundred dollars for  
556 a family of three or more who has contributed or received  
557 contributions of at least five thousand dollars in their health savings  
558 account in the previous year.

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

562 (c) Notwithstanding the provisions of subsection (a) of this section,  
563 the Connecticut Connector shall not make contributions to the health  
564 savings account of any individual if the total amount in such account  
565 exceeds the deductible amount in the high deductible health plan.

566 (d) The Connecticut Connector shall make payments, in accordance  
567 with the provisions of this section, by January thirtieth of any year for  
568 health savings account contributions in the prior calendar year. The  
569 Health Reinsurance Association shall establish procedures by which  
570 individuals may claim payment pursuant to this section.

571 Sec. 9. (NEW) (*Effective October 1, 2009*) (a) There is established the  
572 premium subsidy program. To be eligible for payment pursuant to this  
573 section, an individual (1) shall not have family income greater than  
574 three hundred per cent of the federal poverty level, (2) shall not  
575 individually or as part of a family own a health savings account  
576 pursuant to section 223 of the Internal Revenue Code of 1986, or any  
577 subsequent corresponding internal revenue code of the United States,  
578 as from time to time amended, and (3) shall have an affordable health  
579 care plan purchased through the Connecticut Connector, as defined in  
580 section 3 of this act, or any group health insurance policy providing  
581 coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and  
582 (12) of section 38a-469 of the general statutes for which the employee

583 pays at least five hundred dollars in premiums annually to the  
584 employee's employer if single and at least one thousand dollars in  
585 premiums annually to the employee's employer if the employee is  
586 covered by a family plan or under a nonemployer-based plan  
587 purchased through the individual market or the Connecticut  
588 Connector. The Connecticut Connector shall quarterly reimburse an  
589 individual who is eligible pursuant to this section for premiums paid  
590 in the preceding quarter an average amount as follows:

591 (A) For a family with income equal to or less than two hundred per  
592 cent of the federal poverty level, eighty per cent of the individual  
593 premium or of their share of the premium for an employer-sponsored  
594 plan, not to exceed three hundred dollars per quarter for an individual,  
595 six hundred dollars per quarter for an individual plus one dependent  
596 or nine hundred dollars per quarter for a family;

597 (B) For a family with income greater than two hundred per cent but  
598 less than three hundred per cent of the federal poverty level, sixty per  
599 cent of the individual premium or of their share of the premium for an  
600 employer-sponsored plan, not to exceed one hundred fifty dollars per  
601 quarter for an individual, three hundred dollars per quarter for an  
602 individual plus one dependent or four hundred fifty dollars per  
603 quarter for a family.

604 (b) The dollar amounts specified in subparagraphs (A) and (B) of  
605 subdivision (3) of subsection (a) of this section shall be adjusted in the  
606 case of an individual seeking payment for the purchase of an  
607 individual insurance plan based on the age, gender and county of  
608 residence of the individual and calculated by the Connecticut  
609 Connector to reflect the differences in premiums applied to each rating  
610 classification.

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

615 (d) The Health Reinsurance Association shall establish procedures  
616 by which individuals may claim payment pursuant to this section.

617 Sec. 10. Section 38a-567 of the general statutes is repealed and the  
618 following is substituted in lieu thereof (*Effective January 1, 2009*):

619 Health insurance plans and insurance arrangements covering small  
620 employers and insurers and producers marketing such plans and  
621 arrangements shall be subject to the following provisions:

622 (1) (A) Any such plan or arrangement shall be renewable with  
623 respect to all eligible employees or dependents at the option of the  
624 small employer, policyholder or contract-holder, as the case may be,  
625 except: (i) For nonpayment of the required premiums by the small  
626 employer, policyholder or contract-holder; (ii) for fraud or  
627 misrepresentation of the small employer, policyholder or  
628 contractholder or, with respect to coverage of individual insured, the  
629 insureds or their representatives; (iii) for noncompliance with plan or  
630 arrangement provisions; (iv) when the number of insureds covered  
631 under the plan or arrangement is less than the number of insureds or  
632 percentage of insureds required by participation requirements under  
633 the plan or arrangement; or (v) when the small employer, policyholder  
634 or contractholder is no longer actively engaged in the business in  
635 which it was engaged on the effective date of the plan or arrangement.

636 (B) Renewability of coverage may be effected by either continuing in  
637 effect a plan or arrangement covering a small employer or by  
638 substituting upon renewal for the prior plan or arrangement the plan  
639 or arrangement then offered by the carrier that most closely  
640 corresponds to the prior plan or arrangement and is available to other  
641 small employers. Such substitution shall only be made under  
642 conditions approved by the commissioner. A carrier may substitute a  
643 plan or arrangement as stated above only if the carrier effects the same  
644 substitution upon renewal for all small employers previously covered  
645 under the particular plan or arrangement, unless otherwise approved  
646 by the commissioner. The substitute plan or arrangement shall be

647 subject to the rating restrictions specified in this section on the same  
648 basis as if no substitution had occurred, except for an adjustment  
649 based on coverage differences.

650 (C) Notwithstanding the provisions of this subdivision, any such  
651 plan or arrangement, or any coverage provided under such plan or  
652 arrangement may be rescinded for fraud, material misrepresentation  
653 or concealment by an applicant, employee, dependent or small  
654 employer.

655 (D) Any individual who was not a late enrollee at the time of his or  
656 her enrollment and whose coverage is subsequently rescinded shall be  
657 allowed to reenroll as of a current date in such plan or arrangement  
658 subject to any preexisting condition or other provisions applicable to  
659 new enrollees without previous coverage. On and after the effective  
660 date of such individual's reenrollment, the small employer carrier may  
661 modify the premium rates charged to the small employer for the  
662 balance of the current rating period and for future rating periods, to  
663 the level determined by the carrier as applicable under the carrier's  
664 established rating practices had full, accurate and timely underwriting  
665 information been supplied when such individual initially enrolled in  
666 the plan. The increase in premium rates allowed by this provision for  
667 the balance of the current rating period shall not exceed twenty-five  
668 per cent of the small employer's current premium rates. Any such  
669 increase for the balance of said current rating period shall not be  
670 subject to the rate limitation specified in subdivision (6) of this section.  
671 The rate limitation specified in this section shall otherwise be fully  
672 applicable for the current and future rating periods. The modification  
673 of premium rates allowed by this subdivision shall cease to be  
674 permitted for all plans and arrangements on the first rating period  
675 commencing on or after July 1, 1995.

676 (2) Except in the case of a late enrollee who has failed to provide  
677 evidence of insurability satisfactory to the insurer, the plan or  
678 arrangement may not exclude any eligible employee or dependent

679 who would otherwise be covered under such plan or arrangement on  
680 the basis of an actual or expected health condition of such person. No  
681 plan or arrangement may exclude an eligible employee or eligible  
682 dependent who, on the day prior to the initial effective date of the plan  
683 or arrangement, was covered under the small employer's prior health  
684 insurance plan or arrangement pursuant to workers' compensation,  
685 continuation of benefits pursuant to federal extension requirements  
686 established by the Consolidated Omnibus Budget Reconciliation Act of  
687 1985 (P.L. 99-2721, as amended) or other applicable laws. The  
688 employee or dependent must request coverage under the new plan or  
689 arrangement on a timely basis and such coverage shall terminate in  
690 accordance with the provisions of the applicable law.

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

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

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

706 (A) The percentage change in the base premium rate measured from  
707 the first day of the prior rating period to the first day of the new rating  
708 period;

709 (B) An adjustment of the small employer's premium rates for the

710 prior rating period, and adjusted pro rata for rating periods of less  
711 than one year, due to the claim experience, health status or duration of  
712 coverage of the employees or dependents of the small employer, such  
713 adjustment (i) not to exceed ten per cent annually for the rating  
714 periods commencing on or after October 1, 1993, and prior to July 1,  
715 1994, and (ii) not to exceed five per cent annually for the rating periods  
716 commencing on or after July 1, 1994, and prior to July 1, 1995; and

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

720 (5) (A) With respect to plans or arrangements delivered, issued for  
721 delivery, renewed, amended or continued in this state on or after [July  
722 1, 1995] January 1, 2009, the premium rates charged or offered to small  
723 employers shall be established on the basis of a community rate,  
724 adjusted to reflect one or more of the following classifications:

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

727 (ii) Gender;

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

730 (iv) Industry, provided the rate factor associated with any industry  
731 classification shall not vary from the arithmetic average of the highest  
732 and lowest rate factors associated with all industry classifications by  
733 greater than fifteen per cent of such average, and provided further, the  
734 rate factors associated with any industry shall not be increased by  
735 more than five per cent per year;

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

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

746 (vii) Savings resulting from a reduction in the profit of a carrier who  
747 writes small business plans or arrangements for an association group  
748 plan or a plan written pursuant to section 5-259 provided any loss in  
749 overall revenue due to a reduction in profit is not shifted to other small  
750 employers; [and]

751 (viii) Family composition, provided the small employer carrier shall  
752 utilize only one or more of the following billing classifications: (I)  
753 Employee; (II) employee plus family; (III) employee and spouse; (IV)  
754 employee and child; (V) employee plus one dependent; and (VI)  
755 employee plus two or more dependents; and

756 (ix) Participation in a nonsmoking program that complies with  
757 HIPAA.

758 (B) The small employer carrier shall quote premium rates to small  
759 employers after receipt of all demographic rating classifications of the  
760 small employer group. No small employer carrier may inquire  
761 regarding health status or claims experience of the small employer or  
762 its employees or dependents prior to the quoting of a premium rate.

763 (C) The provisions of subparagraphs (A) and (B) of this subdivision  
764 shall apply to plans or arrangements issued on or after July 1, 1995.  
765 The provisions of subparagraphs (A) and (B) of this subdivision shall  
766 apply to plans or arrangements issued prior to July 1, 1995, as of the  
767 date of the first rating period commencing on or after that date, but no  
768 later than July 1, 1996.

769 (6) For any small employer plan or arrangement on which the  
770 premium rates for employee and dependent coverage or both, vary  
771 among employees, such variations shall be based solely on age and  
772 other demographic factors permitted under subparagraph (A) of  
773 subdivision (5) of this section and such variations may not be based on  
774 health status, claim experience, or duration of coverage of specific  
775 enrollees. Except as otherwise provided in subdivision (1) of this  
776 section, any adjustment in premium rates charged for a small  
777 employer plan or arrangement to reflect changes in case characteristics  
778 prior to the end of a rating period shall not include any adjustment to  
779 reflect the health status, medical history or medical underwriting  
780 classification of any new enrollee for whom coverage begins during  
781 the rating period.

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

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

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

801 (10) If a small employer carrier denies coverage to a small employer,  
802 the small employer carrier shall promptly offer the small employer the  
803 opportunity to purchase a special health care plan or a small employer  
804 health care plan, as appropriate. If a small employer carrier or any  
805 producer representing that carrier fails, for any reason, to offer such  
806 coverage as requested by a small employer, that small employer carrier  
807 shall promptly offer the small employer an opportunity to purchase a  
808 special health care plan or a small employer health care plan, as  
809 appropriate.

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

812 (A) Encouraging or directing small employers to refrain from filing  
813 an application for coverage with the small employer carrier because of  
814 the health status, claims experience, industry, occupation or  
815 geographic location of the small employer, except the provisions of  
816 this subparagraph shall not apply to information provided by a small  
817 employer carrier or producer to a small employer regarding the  
818 carrier's established geographic service area or a restricted network  
819 provision of a small employer carrier; or

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

823 (12) No small employer carrier shall, directly or indirectly, enter into  
824 any contract, agreement or arrangement with a producer that provides  
825 for or results in the compensation paid to a producer for the sale of a  
826 health benefit plan to be varied because of the health status, claims  
827 experience, industry, occupation or geographic area of the small  
828 employer. A small employer carrier shall provide reasonable  
829 compensation, as provided under the plan of operation of the  
830 program, to a producer, if any, for the sale of a special or a small  
831 employer health care plan. No small employer carrier shall terminate,  
832 fail to renew or limit its contract or agreement of representation with a

833 producer for any reason related to the health status, claims experience,  
834 occupation, or geographic location of the small employers placed by  
835 the producer with the small employer carrier.

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

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

843 (15) No small employer carrier or producer shall disclose (A) to a  
844 small employer the fact that any or all of the eligible employees of such  
845 small employer have been or will be reinsured with the pool, or (B) to  
846 any eligible employee or dependent the fact that he has been or will be  
847 reinsured with the pool.

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

853 (17) The commissioner may adopt regulations<sub>2</sub> in accordance with  
854 the provisions of chapter 54<sub>2</sub> setting forth additional standards to  
855 provide for the fair marketing and broad availability of health benefit  
856 plans to small employers.

857 (18) Each small employer carrier shall maintain at its principle place  
858 of business a complete and detailed description of its rating practices  
859 and renewal underwriting practices, including information and  
860 documentation that demonstrates that its rating methods and practices  
861 are based upon commonly accepted actuarial assumptions and are in  
862 accordance with sound actuarial principles. Each small employer

863 carrier shall file with the commissioner annually, on or before March  
864 fifteenth, an actuarial certification certifying that the carrier is in  
865 compliance with this part and that the rating methods have been  
866 derived using recognized actuarial principles consistent with the  
867 provisions of sections 38a-564 to 38a-573, inclusive. Such certification  
868 shall be in a form and manner and shall contain such information, as  
869 determined by the commissioner. A copy of the certification shall be  
870 retained by the small employer carrier at its principle place of business.  
871 Any information and documentation described in this subdivision but  
872 not subject to the filing requirement shall be made available to the  
873 commissioner upon his request. Except in cases of violations of  
874 sections 38a-564 to 38a-573, inclusive, the information shall be  
875 considered proprietary and trade secret information and shall not be  
876 subject to disclosure by the commissioner to persons outside of the  
877 department except as agreed to by the small employer carrier or as  
878 ordered by a court of competent jurisdiction.

879 (19) The commissioner may suspend all or any part of this section  
880 relating to the premium rates applicable to one or more small  
881 employers for one or more rating periods upon a filing by the small  
882 employer carrier and a finding by the commissioner that either the  
883 suspension is reasonable in light of the financial condition of the  
884 carrier or that the suspension would enhance the efficiency and  
885 fairness of the marketplace for small employer health insurance.

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

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

894 (22) With respect to plans or arrangements issued pursuant to

895 subsection (i) of section 5-259, or by an association group plan, at the  
896 option of the Comptroller or the administrator of the association group  
897 plan, the premium rates charged or offered to small employers  
898 purchasing health insurance shall not be subject to this section,  
899 provided (A) the plan or plans offered or issued cover such small  
900 employers as a single entity and cover not less than ten thousand  
901 eligible individuals on the date issued, (B) each small employer is  
902 charged or offered the same premium rate with respect to each eligible  
903 individual and dependent, and (C) the plan or plans are written on a  
904 guaranteed issue basis.

905 Sec. 11. (NEW) (*Effective July 1, 2008*) The Department of Public  
906 Health shall establish and offer incentives for physicians in private  
907 practice who provide their services for at least four hours to federally  
908 qualified health centers, community health centers, community mental  
909 health centers or school-based clinics. Such incentives may include, but  
910 not be limited to, reduced cost medical malpractice insurance offered  
911 or arranged for by the department and loan forgiveness from  
912 postsecondary educational institutions that receive funding from the  
913 state and partial payment of educational loans.

914 Sec. 12. (NEW) (*Effective July 1, 2008*) Not later than January 1, 2009,  
915 the Department of Public Health shall expand the Connecticut Tobacco  
916 Use Prevention and Control Plan to offer, within available  
917 appropriations, smoking cessation medication and supplies, including,  
918 but not limited to, nicotine replacement therapy.

919 Sec. 13. (NEW) (*Effective January 1, 2009*) (a) The Health Care Reform  
920 Commission, established under section 2 of this act, shall establish a  
921 subcommittee on healthy lifestyles, comprised of six members of said  
922 commission, to be selected by the Commissioner of HealthCare Access.  
923 The subcommittee shall: (1) Not later than March 1, 2010, develop a  
924 marketing campaign to educate the public regarding consequences of  
925 poor health and basic measures individuals should take to ensure  
926 good health; and (2) make recommendations to the General Assembly

927 concerning incentives to encourage personal responsibility in making  
928 healthy lifestyle choices.

929 (b) The subcommittee shall meet at least quarterly each year. The  
930 commission, within available appropriations, may hire consultants to  
931 provide assistance to the subcommittee with its responsibilities.

932 (c) The Office of Health Care Access shall, within available  
933 appropriations, contract with one or more entities to implement the  
934 marketing campaign recommended by the subcommittee on healthy  
935 lifestyles.

936 Sec. 14. (NEW) (*Effective July 1, 2008*) (a) Not later than July 1, 2009,  
937 the Health Care Reform Commission, established under section 2 of  
938 this act, shall establish the Connecticut Health Quality Partnership.  
939 The members of the partnership shall appointed by the Commissioner  
940 of HealthCare Access, and shall consist of be a minimum of eight  
941 representatives from both the private and public sectors, including, but  
942 not limited to, health insurers, hospital associations, a representative of  
943 physicians, the Commissioners of Public Health and Social Services or  
944 their designees, representatives of Medicaid managed care  
945 organizations and not more than two consumer advocates who are not  
946 otherwise affiliated with any other members. The commission shall  
947 assign staff to assist the partnership with its responsibilities.

948 (b) The Connecticut Health Quality Partnership shall: (1) Be  
949 responsible for collecting and analyzing insurance and Medicaid  
950 claims data and other data concerning the quality of care and services  
951 provided by health care providers, for the purpose of supporting  
952 quality improvement initiatives and enabling consumers to make  
953 informed choices with respect to such health care providers; (2)  
954 provide comparative data to health care providers concerning the  
955 quality of their performance relative to their peers; (3) be responsible  
956 for collecting and analyzing data from hospitals pertaining to  
957 nosocomial infections for the purpose of tracking, reporting and  
958 reducing nosocomial infection rates; (4) be responsible for collecting

959 and analyzing such data from other health care providers, as it deems  
960 necessary; (5) be responsible for annually selecting state-wide quality  
961 improvement initiatives and encouraging all health plans to adopt  
962 such quality improvement initiatives with the same goals and metrics;  
963 (6) seek funding from private and federal funding sources; and (7) seek  
964 accreditation not later than July 1, 2013, by the National Committee for  
965 Quality Assurance as a Quality Plus program.

966 Sec. 15. (NEW) (*Effective October 1, 2008*) (a) Not later than January 1,  
967 2009, and every five years thereafter, the Office of Health Care Access  
968 shall determine the number of residents of this state who are not  
969 covered by a health insurance plan. If, by January 1, 2014, the number  
970 of uninsured residents has not decreased by fifty per cent from the  
971 date of the first determination, the Health Care Reform Commission  
972 established by section 2 of this act, shall determine whether it is  
973 advisable to require all or certain residents to have health insurance.  
974 Not later than January 1, 2015, the commission shall report its findings  
975 and recommendations to the joint standing committee of the General  
976 Assembly having cognizance of matters relating to insurance, in  
977 accordance with section 11-4a of the general statutes.

978 (b) Not later than December 31, 2009, and annually thereafter, the  
979 Office of Health Care Access shall conduct a survey to determine the  
980 number of employers in the state providing health care benefits to  
981 employees who reside in this state. Not later than January 1, 2010, and  
982 annually thereafter, the office shall submit a report of its findings to  
983 the joint standing committee of the General Assembly having  
984 cognizance of matters relating to insurance, in accordance with section  
985 11-4a of the general statutes.

986 Sec. 16. (*Effective July 1, 2008*) (a) The Commissioner of Public Health  
987 shall identify and evaluate current programs that provide services to  
988 residents of this state who are uninsured.

989 (b) Not later than September 1, 2009, the Commissioner of Public  
990 Health shall submit a report, in accordance with section 11-4a of the

991 general statutes, of findings and recommendations to the joint  
992 standing committees of the General Assembly having cognizance of  
993 matters relating to public health and appropriations and the budgets of  
994 state agencies. Such report shall identify the programs that are likely to  
995 experience a decrease in utilization due to the implementation of the  
996 programs and plans established under the Connecticut Healthy Steps  
997 program and the amount of such decrease, to the extent feasible.

998       Sec. 17. (NEW) (*Effective July 1, 2008*) The Office of Health Care  
999 Access shall utilize the data obtained pursuant to section 15 of this act  
1000 relative to any decreases in the number of uninsured residents of this  
1001 state to make recommendations to the Department of Social Services  
1002 for commensurate decreases in the disproportionate share payments to  
1003 hospitals in accordance with the provisions of section 19a-671 of the  
1004 2008 supplement to the general statutes.

1005       Sec. 18. (NEW) (*Effective \_\_\_\_*) The Commissioner of Social Services  
1006 shall establish an excess cost reinsurance program to carry out the  
1007 provisions of subparagraph (D) of subdivision (1) of subsection (b) of  
1008 section 4 of this act. Such program shall (1) disregard assets equal to  
1009 the amount of insurance premium payments paid by an insured for an  
1010 affordable health care plan for the two years prior to Medicaid  
1011 application, and (2) disregard as income the amount of insurance  
1012 premium payments made by an insured for an affordable health care  
1013 plan in the year of Medicaid application. Said commissioner may  
1014 adopt regulations, in accordance with chapter 54 of the general  
1015 statutes, to implement the requirements of this section.

1016       Sec. 19. (NEW) (*Effective July 1, 2008*) Not later than December 31,  
1017 2008, the Commissioner of Social Services shall seek a waiver or  
1018 waivers of federal Medicaid rules for the purposes of (1) obtaining any  
1019 available federal reimbursement, including federal financial  
1020 participation, for state expenditures related to the health savings  
1021 account incentive program established under section 8 of this act and  
1022 the premium subsidy program established under section 9 of this act,

1023 and (2) establishing a state excess cost reinsurance program for  
1024 enrollees in the Connecticut Connector's affordable health care plan to  
1025 allow such enrollees to obtain coverage through the Medicaid program  
1026 once their insurance benefits are exhausted without having to spend  
1027 down their assets.

1028       Sec. 20. (NEW) (*Effective July 1, 2008*) (a) The Commissioner of Social  
1029 Services shall develop a plan to improve the coordination of the  
1030 delivery of health care services to all or a substantial subset of the  
1031 aged, blind and disabled Medicaid beneficiaries. Such plan shall  
1032 include programs to (1) improve coordination of and access to medical  
1033 services, social services and housing, (2) implement chronic disease  
1034 management programs, (3) use predictive modeling to identify high  
1035 risk, complex and high-cost Medicaid beneficiaries, and (4) provide  
1036 such beneficiaries with intensive clinical care coordination and  
1037 pharmacological management. The commissioner may contract with  
1038 an administrative services organization to effectuate the  
1039 implementation of such plan.

1040       (b) Such plan shall also address: (1) Provider reimbursement  
1041 systems that are aligned with the goal of managing the care of  
1042 individuals who have, or are at risk for having, chronic health  
1043 conditions in order to improve health outcomes and the quality of care  
1044 for such individuals; and (2) the use and development of outcome  
1045 measures and reporting requirements, aligned with existing outcome  
1046 measures within the Department of Social Services, to assess and  
1047 evaluate the system of chronic care.

1048       (c) Not later than January 1, 2009, the Commissioner of Social  
1049 Services shall submit such plan, in accordance with section 11-4a of the  
1050 general statutes, to the joint standing committees of the General  
1051 Assembly having cognizance of matters relating to human services and  
1052 appropriations and the budgets of state agencies. On October 1, 2010,  
1053 and annually thereafter, the Commissioner of Social Services shall  
1054 report, in accordance with the provisions of section 11-4a of the general

1055 statutes, on the status of implementation of such plan to the joint  
1056 standing committees of the General Assembly having cognizance of  
1057 matters relating to human services and appropriations and the budgets  
1058 of state agencies. The report shall include the number of individuals  
1059 and health care providers participating in the programs specified in  
1060 subsection (a) of this section, indicators of quality improvement and  
1061 patient satisfaction, annual expenditures and savings associated with  
1062 the plan and such other information as may be requested by said joint  
1063 standing committees.

1064       Sec. 21. (NEW) (*Effective July 1, 2008*) On and after January 1, 2009,  
1065 the Commissioner of Social Services shall allow aged, blind or disabled  
1066 Medicaid beneficiaries to voluntarily enroll in the managed care plans  
1067 available to HUSKY Plan, Part A and HUSKY Plan, Part B  
1068 beneficiaries.

1069       Sec. 22. Subsection (a) of section 17b-192 of the 2008 supplement to  
1070 the general statutes, is repealed and the following is substituted in lieu  
1071 thereof (*Effective July 1, 2008*):

1072       (a) The Commissioner of Social Services shall implement a state  
1073 medical assistance component of the state-administered general  
1074 assistance program for persons ineligible for Medicaid. Eligibility  
1075 criteria concerning income shall be the same as the medically needy  
1076 component of the Medicaid program as utilized on June 30, 2008,  
1077 except that earned monthly gross income of up to one hundred fifty  
1078 dollars shall be disregarded. Unearned income shall not be  
1079 disregarded. No person who has family assets exceeding one thousand  
1080 dollars shall be eligible. No person shall be eligible for assistance  
1081 under this section if such person made, during the three months prior  
1082 to the month of application, an assignment or transfer or other  
1083 disposition of property for less than fair market value. The number of  
1084 months of ineligibility due to such disposition shall be determined by  
1085 dividing the fair market value of such property, less any consideration  
1086 received in exchange for its disposition, by five hundred dollars. Such

1087 period of ineligibility shall commence in the month in which the  
1088 person is otherwise eligible for benefits. Any assignment, transfer or  
1089 other disposition of property, on the part of the transferor, shall be  
1090 presumed to have been made for the purpose of establishing eligibility  
1091 for benefits or services unless such person provides convincing  
1092 evidence to establish that the transaction was exclusively for some  
1093 other purpose.

1094 Sec. 23. Section 17b-261 of the 2008 supplement to the general  
1095 statutes is amended by adding subsections (j) and (k) as follows  
1096 (*Effective July 1, 2008*):

1097 (NEW) (j) Notwithstanding the provisions of this section, the  
1098 Commissioner of Social Services, pursuant to 42 USC 1396a(r)(2), shall  
1099 file an amendment to the Medicaid state plan that allows said  
1100 commissioner, when making Medicaid income eligibility  
1101 determinations, to establish a special income disregard applicable only  
1102 to the Medicaid program that permits individuals who are aged, blind  
1103 or disabled and who have income that is not greater than one hundred  
1104 per cent of the federal poverty level to qualify for Medicaid.

1105 (NEW) (k) To the extent permitted by federal law, the  
1106 Commissioner of Social Services may impose copayments on persons  
1107 eligible for medical assistance under the provisions of this section who  
1108 utilize the emergency room of a hospital to access services of a  
1109 nonemergency nature. Services of a nonemergency nature shall be  
1110 defined by the commissioner after consultation with representative  
1111 staff of emergency rooms throughout the state. Prior to imposing any  
1112 such copayments, the commissioner shall provide not less than thirty  
1113 days written notice to all persons eligible for medical assistance under  
1114 this section advising such persons of the impending implementation of  
1115 copayments and the Department of Social Services' policies that will be  
1116 applicable to such copayments. The first instance of emergency room  
1117 use by an eligible person to access services of a nonemergency nature  
1118 shall not result in the imposition of a copayment, but the staff at such

1119 emergency room shall provide verbal and written notice, in a manner  
1120 prescribed by the commissioner, that advises such person that  
1121 continued use of the emergency room for services of a nonemergency  
1122 nature shall result in the imposition of copayments on the recipient  
1123 and that such person should seek nonemergency care from other  
1124 providers assigned to provide medical assistance to such person in  
1125 accordance with the provisions of this section. Any copayment  
1126 imposed pursuant to this subsection shall not exceed the sum of  
1127 twenty-five dollars per visit and the hospital shall have the discretion  
1128 to waive collection of the copayment based on a determination of  
1129 hardship or otherwise. The commissioner shall not deduct any  
1130 copayment imposed pursuant to this subsection from payments that  
1131 are due and owing from the department to such emergency room.

1132 Sec. 24. Section 17b-292 of the 2008 supplement to the general  
1133 statutes, is repealed and the following is substituted in lieu thereof  
1134 (*Effective July 1, 2008*):

1135 (a) A child who resides in a household with a family income which  
1136 exceeds one hundred eighty-five per cent of the federal poverty level  
1137 and does not exceed three hundred per cent of the federal poverty  
1138 level may be eligible for subsidized benefits under the HUSKY Plan,  
1139 Part B.

1140 (b) A child who resides in a household with a family income over  
1141 three hundred per cent of the federal poverty level may be eligible for  
1142 unsubsidized benefits under the HUSKY Plan, Part B.

1143 (c) Whenever a court or family support magistrate orders a  
1144 noncustodial parent to provide health insurance for a child, such  
1145 parent may provide for coverage under the HUSKY Plan, Part B.

1146 (d) On and after January 1, 2009, a child who is determined to be  
1147 eligible for benefits under either the HUSKY Plan, Part A or Part B,  
1148 shall remain eligible for such plan for a period of twelve months from  
1149 such child's determination of eligibility unless the child attains the age

1150 of nineteen or is no longer a resident of the state. An adult who is  
1151 determined to be eligible for benefits under the HUSKY Plan, Part A  
1152 shall, unless otherwise precluded under federal law, remain eligible  
1153 for such plan for a period of twelve months from such adult's  
1154 determination of eligibility unless the adult is no longer a resident of  
1155 the state. During the twelve-month period following the date that an  
1156 adult or child is determined eligible for the HUSKY Plan, Part A or  
1157 Part B, the adult or family of such child shall comply with federal  
1158 requirements concerning the reporting of information to the  
1159 department, including, but not limited to, change of address  
1160 information.

1161 [(d)] (e) To the extent allowed under federal law, the commissioner  
1162 shall not pay for services or durable medical equipment under the  
1163 HUSKY Plan, Part B if the enrollee has other insurance coverage for  
1164 the services or such equipment.

1165 [(e)] (f) A newborn child who otherwise meets the eligibility criteria  
1166 for the HUSKY Plan, Part B shall be eligible for benefits retroactive to  
1167 his or her date of birth, provided an application is filed on behalf of the  
1168 child not later than thirty days after such date. Any uninsured child  
1169 born in a hospital in this state or in a border state hospital shall be  
1170 enrolled on an expedited basis in the HUSKY Plan, Part B, provided (1)  
1171 the parent or caretaker relative of such child resides in this state, and  
1172 (2) the parent or caretaker relative of such child authorizes enrollment  
1173 in the program. The commissioner shall pay any premium cost such  
1174 family would otherwise incur for the first four months of coverage to  
1175 the managed care organization selected by the parent or caretaker  
1176 relative to provide coverage for such child.

1177 [(f)] (g) The commissioner shall implement presumptive eligibility  
1178 for children applying for Medicaid. Such presumptive eligibility  
1179 determinations shall be in accordance with applicable federal law and  
1180 regulations. The commissioner shall adopt regulations, in accordance  
1181 with chapter 54, to establish standards and procedures for the

1182 designation of organizations as qualified entities to grant presumptive  
1183 eligibility. Qualified entities shall ensure that, at the time a  
1184 presumptive eligibility determination is made, a completed application  
1185 for Medicaid is submitted to the department for a full eligibility  
1186 determination. In establishing such standards and procedures, the  
1187 commissioner shall ensure the representation of state-wide and local  
1188 organizations that provide services to children of all ages in each  
1189 region of the state.

1190 [(g)] (h) The commissioner shall provide for a single point of entry  
1191 servicer for applicants and enrollees under the HUSKY Plan, Part A  
1192 and Part B. The commissioner, in consultation with the servicer, shall  
1193 establish a centralized unit to be responsible for processing all  
1194 applications for assistance under the HUSKY Plan, Part A and Part B.  
1195 The department, through its servicer, shall ensure that a child who is  
1196 determined to be eligible for benefits under the HUSKY Plan, Part A,  
1197 or the HUSKY Plan, Part B has uninterrupted health insurance  
1198 coverage for as long as the parent or guardian elects to enroll or re-  
1199 enroll such child in the HUSKY Plan, Part A or Part B. The  
1200 commissioner, in consultation with the servicer, and in accordance  
1201 with the provisions of section 17b-297 of the 2008 supplement to the  
1202 general statutes, shall jointly market both Part A and Part B together as  
1203 the HUSKY Plan and shall develop and implement public information  
1204 and outreach activities with community programs. Such servicer shall  
1205 electronically transmit data with respect to enrollment and  
1206 disenrollment in the HUSKY Plan, Part A and Part B to the  
1207 commissioner.

1208 [(h)] (i) Upon the expiration of any contractual provisions entered  
1209 into pursuant to subsection [(g)] (h) of this section, the commissioner  
1210 shall develop a new contract for single point of entry services and  
1211 managed care enrollment brokerage services. The commissioner may  
1212 enter into one or more contractual arrangements for such services for a  
1213 contract period not to exceed seven years. Such contracts shall include  
1214 performance measures, including, but not limited to, specified time

1215 limits for the processing of applications, parameters setting forth the  
1216 requirements for a completed and reviewable application and the  
1217 percentage of applications forwarded to the department in a complete  
1218 and timely fashion. Such contracts shall also include a process for  
1219 identifying and correcting noncompliance with established  
1220 performance measures, including sanctions applicable for instances of  
1221 continued noncompliance with performance measures.

1222 [(i)] (j) The single point of entry servicer shall send all applications  
1223 and supporting documents to the commissioner for determination of  
1224 eligibility. The servicer shall enroll eligible beneficiaries in the  
1225 applicant's choice of managed care plan. Upon enrollment in a  
1226 managed care plan, an eligible HUSKY Plan Part A or Part B  
1227 beneficiary shall remain enrolled in such managed care plan for twelve  
1228 months from the date of such enrollment unless (1) an eligible  
1229 beneficiary demonstrates good cause to the satisfaction of the  
1230 commissioner of the need to enroll in a different managed care plan, or  
1231 (2) the beneficiary no longer meets program eligibility requirements.

1232 [(j)] (k) Not later than ten months after the determination of  
1233 eligibility for benefits under the HUSKY Plan, Part A and Part B and  
1234 annually thereafter, the commissioner or the servicer, as the case may  
1235 be, shall within existing budgetary resources, mail or, upon request of  
1236 a participant, electronically transmit an application form to each  
1237 participant in the plan for the purposes of obtaining information to  
1238 make a determination on continued eligibility beyond the twelve  
1239 months of initial eligibility. To the extent permitted by federal law, in  
1240 determining eligibility for benefits under the HUSKY Plan, Part A or  
1241 Part B with respect to family income, the commissioner or the servicer  
1242 shall rely upon information provided in such form by the participant  
1243 unless the commissioner or the servicer has reason to believe that such  
1244 information is inaccurate or incomplete. The Department of Social  
1245 Services shall annually review a random sample of cases to confirm  
1246 that, based on the statistical sample, relying on such information is not  
1247 resulting in ineligible clients receiving benefits under HUSKY Plan

1248 Part A or Part B. The determination of eligibility shall be coordinated  
1249 with health plan open enrollment periods.

1250 [(k)] (l) The commissioner shall implement the HUSKY Plan, Part B  
1251 while in the process of adopting necessary policies and procedures in  
1252 regulation form in accordance with the provisions of section 17b-10.

1253 [(l)] (m) The commissioner shall adopt regulations, in accordance  
1254 with chapter 54, to establish residency requirements and income  
1255 eligibility for participation in the HUSKY Plan, Part B and procedures  
1256 for a simplified mail-in application process. Notwithstanding the  
1257 provisions of section 17b-257b, such regulations shall provide that any  
1258 child adopted from another country by an individual who is a citizen  
1259 of the United States and a resident of this state shall be eligible for  
1260 benefits under the HUSKY Plan, Part B upon arrival in this state.

1261 Sec. 25. Section 17b-267 of the general statutes is repealed and the  
1262 following is substituted in lieu thereof (*Effective July 1, 2009*):

1263 (a) If any group or association of providers of medical assistance  
1264 services wishes to have payments as provided for under sections 17b-  
1265 260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, of the 2008  
1266 supplement to the general statutes, as amended by this act, and 17b-  
1267 357 to 17b-361, inclusive, to such providers made through a national,  
1268 state or other public or private agency or organization and nominates  
1269 such agency or organization for this purpose, the Commissioner of  
1270 Social Services is authorized to enter into an agreement with such  
1271 agency or organization providing for the determination by such  
1272 agency or organization, subject to such review by the Commissioner of  
1273 Social Services as may be provided for by the agreement, of the  
1274 payments required to be made to such providers at the rates set by the  
1275 hospital cost commission, and for the making of such payments by  
1276 such agency or organization to such providers. Such agreement may  
1277 also include provision for the agency or organization to do all or any  
1278 part of the following: With respect to the providers of services which  
1279 are to receive payments through it, (1) to serve as a center for, and to

1280 communicate to providers, any information or instructions furnished  
1281 to it by the Commissioner of Social Services, and to serve as a channel  
1282 of communication from providers to the Commissioner of Social  
1283 Services; (2) to make such audits of the records of providers as may be  
1284 necessary to insure that proper payments are made under this section;  
1285 and (3) to perform such other functions as are necessary to carry out  
1286 the provisions of sections 17b-267 to 17b-271, inclusive, as amended by  
1287 this act.

1288 (b) The Commissioner of Social Services shall not enter into an  
1289 agreement with any agency or organization under subsection (a) of  
1290 this section unless (1) he finds (A) that to do so is consistent with the  
1291 effective and efficient administration of the medical assistance  
1292 program, and (B) that such agency or organization is willing and able  
1293 to assist the providers to which payments are made through it in the  
1294 application of safeguards against unnecessary utilization of services  
1295 furnished by them to individuals entitled to hospital insurance benefits  
1296 under section 17b-261 of the 2008 supplement to the general statutes,  
1297 as amended by this act, and the agreement provides for such  
1298 assistance, and (2) such agency or organization agrees to furnish to the  
1299 Commissioner of Social Services such of the information acquired by it  
1300 in carrying out its agreement under sections 17b-267 to 17b-271,  
1301 inclusive, as amended by this act, as the Commissioner of Social  
1302 Services may find necessary in performing his functions under said  
1303 sections.

1304 (c) An agreement with any agency or organization under subsection  
1305 (a) of this section may contain such terms and conditions as the  
1306 Commissioner of Social Services finds necessary or appropriate, may  
1307 provide for advances of funds to the agency or organization for the  
1308 making of payments by it under said subsection (a), and shall provide  
1309 for payment by the Commissioner of Social Services of so much of the  
1310 cost of administration of the agency or organization as is determined  
1311 by the Commissioner of Social Services to be necessary and proper for  
1312 carrying out the functions covered by the agreement.

1313        (d) Each managed care plan that enters into, renews or amends a  
1314 contract with the Department of Social Services pursuant to this  
1315 section shall limit its administrative costs to ten per cent of payments  
1316 made pursuant to such contracts. The Commissioner of Social Services  
1317 shall implement policies and procedures to effectuate the purpose of  
1318 this subsection while in the process of adopting such policies or  
1319 procedures in regulation form, provided notice of intention to adopt  
1320 the regulations is printed in the Connecticut Law Journal not later than  
1321 twenty days after implementation and any such policies and  
1322 procedures shall be valid until the time the regulations are effective.  
1323 The Commissioner of Social Services may define administrative costs  
1324 to exclude disease management or other value-added clinical  
1325 programs administered by the managed care plans, but not to exclude  
1326 utilization management, claims, member services or other nonclinical  
1327 functions.

1328        Sec. 26. (NEW) (*Effective July 1, 2008*) To the extent permitted by  
1329 federal law, any employer in the state that offers health care benefits to  
1330 its employees shall offer benefits or premium contributions that are  
1331 equivalent in value to all such employees regardless of any differential  
1332 in the amount of compensation paid to such employees. Nothing in  
1333 this section shall preclude an employer from offering employees with a  
1334 lower amount of compensation a more comprehensive health care  
1335 benefit plan or a higher level of employer premium contribution than  
1336 offered to employees receiving a higher amount of compensation.

1337        Sec. 27. (NEW) (*Effective January 1, 2010, and applicable to income years*  
1338 *commencing on or after January 1, 2010*) (a) For purposes of this section:

1339        (1) "Employer" means any person, firm, business, educational  
1340 institution, nonprofit agency, corporation, limited liability company or  
1341 any other business entity which, on at least fifty per cent of its working  
1342 days during the preceding twelve months, (A) employed ten or fewer  
1343 employees, the majority of whom were employed within the state of  
1344 Connecticut, (B) employed eleven to fifty employees, the majority of

1345 whom were employed within the state of Connecticut, of whom at  
1346 least thirty per cent were paid annualized wages by the employer  
1347 equal to or less than three hundred per cent of the federal poverty level  
1348 for a family of three, or (C) employed more than fifty employees, the  
1349 majority of whom were employed within the state of Connecticut, of  
1350 whom at least seventy-five per cent were paid annualized wages by  
1351 the employer equal to or less than one hundred eighty-five per cent of  
1352 the federal poverty level for a family of three;

1353 (2) "Full-time employee" means any person who is not a temporary  
1354 or seasonal employee, employed by an employer and required to work  
1355 a minimum of thirty-five hours per week; and

1356 (3) "Part-time employee" means any person who is not a temporary  
1357 or seasonal employee, employed by an employer and required to work  
1358 less than thirty-five hours per week.

1359 (b) (1) There is established a tax credit program to assist employers  
1360 with providing health insurance to their employees to achieve the goal  
1361 of ensuring greater access to health insurance for residents of this state.  
1362 Any employer that elects to claim a tax credit pursuant to this section  
1363 shall submit to the Connecticut Connector, as established in section 3  
1364 of this act, a copy of such employer's health insurance plan,  
1365 documentation of employees' wages and proof of such employer's  
1366 premium contributions. If the Connecticut Connector certifies that  
1367 such plan meets or exceeds the type and level of benefits of the  
1368 Affordable Health Care Plans established pursuant to section 2 of this  
1369 act, the Connecticut Connector shall issue a certificate indicating such  
1370 fact.

1371 (2) To qualify for a tax credit pursuant to this section, an employer  
1372 shall (A) obtain a certificate from the Connecticut Connector in  
1373 accordance with this section, and (B) pay a minimum of seventy per  
1374 cent of the cost of an employee's health care benefits or a minimum of  
1375 fifty per cent of the cost of an employee plus dependents' health care  
1376 benefits for full-time employees.

1377 (c) An employer shall be allowed a tax credit against the tax  
1378 imposed under chapter 208 of the general statutes for income years  
1379 commencing on or after January 1, 2010, in the following amounts:

1380 (1) For employers offering such coverage to all full-time employees  
1381 but not to all part-time employees, the credit shall be in an amount  
1382 equal to twenty per cent of the cost of providing health care benefits,  
1383 provided such amount shall not exceed eight hundred dollars per  
1384 employee per year in the case of a policy covering an individual  
1385 employee, one thousand six hundred dollars per employee per year in  
1386 the case of a policy covering an employee and only one other  
1387 individual, or two thousand four hundred dollars per employee per  
1388 year in the case of a policy covering an employee and the family of  
1389 such employee;

1390 (2) For employers offering such coverage to all full-time and part-  
1391 time employees, the credit shall be in an amount equal to thirty per  
1392 cent of the cost of providing health care benefits, provided such  
1393 amount shall not exceed one thousand two hundred dollars per  
1394 employee per year in the case of a policy covering an individual  
1395 employee, two thousand four hundred dollars per employee per year  
1396 in the case of a policy covering an employee and only one other  
1397 individual, or three thousand six hundred dollars per employee per  
1398 year in the case of a policy covering an employee and the family of  
1399 such employee.

1400 (d) An employer qualifying under subsection (b) of this section that  
1401 is a limited liability company, limited liability partnership, limited  
1402 partnership or S corporation, as defined in section 12-284b of the  
1403 general statutes, may distribute a credit to its members and such  
1404 members shall be eligible to use such credit against the tax imposed  
1405 under chapter 229 of the general statutes. The total credit that may be  
1406 distributed shall not be greater than the following:

1407 (1) For employers offering such coverage to all full-time employees  
1408 but not part-time employees, the credit shall be in an amount equal to

1409 twenty per cent of the cost of providing health benefits, provided such  
1410 amount shall not exceed eight hundred dollars per employee per year  
1411 in the case of a policy covering an individual employee, one thousand  
1412 six hundred dollars per employee per year in the case of a policy  
1413 covering an employee and only one other individual, or two thousand  
1414 four hundred dollars per employee per year in the case of a policy  
1415 covering the employee and the family of such employee;

1416 (2) For employers offering such coverage to all full-time and part-  
1417 time employees, the credit shall be in an amount equal to thirty per  
1418 cent of the cost of providing health benefits, provided such amount  
1419 shall not exceed one thousand two hundred dollars per employee per  
1420 year in the case of a policy covering an individual employee, two  
1421 thousand four hundred dollars per employee per year in the case of a  
1422 policy covering an employee and only one other individual, or three  
1423 thousand six hundred dollars per employee per year in the case of a  
1424 policy covering an employee and the family of such employee.

1425 (e) (1) In the event the employer owes less than the value of the  
1426 credit allowed under subsection (c) of this section, the employer shall  
1427 be entitled to a refund from the state in an amount equal to the amount  
1428 of the unused credit.

1429 (2) In the event the individual claiming a credit under subsection (d)  
1430 of this section owes less than the value of the credit allowed under said  
1431 subsection, the individual shall be entitled to a refund from the state in  
1432 an amount equal to the amount of the unused credit.

1433 (f) The dollar amount of the credits in subsections (c) and (d) of this  
1434 section shall be annually indexed to the consumer price index for  
1435 medical care.

1436 Sec. 28. Section 38a-556 of the general statutes is repealed and the  
1437 following is substituted in lieu thereof (*Effective July 1, 2008*):

1438 There is hereby created a nonprofit legal entity to be known as the

1439 Health Reinsurance Association. All insurers, health care centers and  
1440 self-insurers doing business in the state, as a condition to their  
1441 authority to transact the applicable kinds of health insurance defined  
1442 in section 38a-551 and under sections 3 and 4 of this act, shall be  
1443 members of the association. The association shall perform its functions  
1444 under a plan of operation established and approved under subdivision  
1445 (a) of this section, and shall exercise its powers through a board of  
1446 directors established under this section.

1447 (a) (1) The board of directors of the association shall be made up of  
1448 nine individuals selected by participating members, subject to  
1449 approval by the commissioner, two of whom shall be appointed by the  
1450 commissioner on or before July 1, 1993, to represent health care  
1451 centers. To select the initial board of directors, and to initially organize  
1452 the association, the commissioner shall give notice to all members of  
1453 the time and place of the organizational meeting. In determining  
1454 voting rights at the organizational meeting each member shall be  
1455 entitled to vote in person or proxy. The vote shall be a weighted vote  
1456 based upon the net health insurance premium derived from this state  
1457 in the previous calendar year. If the board of directors is not selected  
1458 within sixty days after notice of the organizational meeting, the  
1459 commissioner may appoint the initial board. In approving or selecting  
1460 members of the board, the commissioner may consider, among other  
1461 things, whether all members are fairly represented. Members of the  
1462 board may be reimbursed from the moneys of the association for  
1463 expenses incurred by them as members, but shall not otherwise be  
1464 compensated by the association for their services. (2) The board shall  
1465 submit to the commissioner a plan of operation for the association  
1466 necessary or suitable to assure the fair, reasonable and equitable  
1467 administration of the association. The plan of operation shall become  
1468 effective upon approval in writing by the commissioner consistent  
1469 with the date on which the coverage under sections 38a-505, 38a-546,  
1470 [and] 38a-551 to 38a-559, inclusive, and under sections 3 and 4 of this  
1471 act, must be made available. The commissioner shall, after notice and  
1472 hearing, approve the plan of operation provided such plan is

1473 determined to be suitable to assure the fair, reasonable and equitable  
1474 administration of the association, and provides for the sharing of  
1475 association gains or losses on an equitable proportionate basis. If the  
1476 board fails to submit a suitable plan of operation within one hundred  
1477 eighty days after its appointment, or if at any time thereafter the board  
1478 fails to submit suitable amendments to the plan, the commissioner  
1479 shall, after notice and hearing, adopt and promulgate such reasonable  
1480 rules as are necessary or advisable to effectuate the provisions of this  
1481 section. Such rules shall continue in force until modified by the  
1482 commissioner or superseded by a plan submitted by the board and  
1483 approved by the commissioner. The plan of operation shall, in addition  
1484 to requirements enumerated in sections 38a-505, 38a-546 and 38a-551  
1485 to 38a-559, inclusive: (A) Establish procedures for the handling and  
1486 accounting of assets and moneys of the association; (B) establish  
1487 regular times and places for meetings of the board of directors; (C)  
1488 establish procedures for records to be kept of all financial transactions,  
1489 and for the annual fiscal reporting to the commissioner; (D) establish  
1490 procedures whereby selections for the board of directors shall be made  
1491 and submitted to the commissioner; (E) establish procedures to amend,  
1492 subject to the approval of the commissioner, the plan of operations; (F)  
1493 establish procedures for the selection of an administering carrier and  
1494 set forth the powers and duties of the administering carrier; (G)  
1495 contain additional provisions necessary or proper for the execution of  
1496 the powers and duties of the association; (H) establish procedures for  
1497 the advertisement on behalf of all participating carriers of the general  
1498 availability of the comprehensive coverage under sections 38a-505,  
1499 38a-546 and 38a-551 to 38a-559, inclusive; (I) contain additional  
1500 provisions necessary for the association to qualify as an acceptable  
1501 alternative mechanism in accordance with Section 2744 of the Public  
1502 Health Service Act, as set forth in the Health Insurance Portability and  
1503 Accountability Act of 1996 (P.L. 104-191); and (J) contain additional  
1504 provisions necessary for the association to qualify as acceptable  
1505 coverage in accordance with the Pension Benefit Guaranty Corporation  
1506 and Trade Adjustment Assistance programs of the Trade Act of 2002

1507 (P.L. 107-210). The commissioner may adopt regulations in accordance  
1508 with the provisions of chapter 54 to establish criteria for the association  
1509 to qualify as an acceptable alternative mechanism.

1510 (b) The association shall have the general powers and authority  
1511 granted under the laws of this state to carriers to transact the kinds of  
1512 insurance defined under section 38a-551, and in addition thereto, the  
1513 specific authority to: (1) Enter into contracts necessary or proper to  
1514 carry out the provisions and purposes of sections 38a-505, 38a-546,  
1515 [and] 38a-551 to 38a-559, inclusive, and under sections 3 and 4 of this  
1516 act; (2) sue or be sued, including taking any legal actions necessary or  
1517 proper for recovery of any assessments for, on behalf of, or against  
1518 participating members; (3) take such legal action as necessary to avoid  
1519 the payment of improper claims against the association or the coverage  
1520 provided by or through the association; (4) establish, with respect to  
1521 health insurance provided by or on behalf of the association,  
1522 appropriate rates, scales of rates, rate classifications and rating  
1523 adjustments, such rates not to be unreasonable in relation to the  
1524 coverage provided and the operational expenses of the association; (5)  
1525 administer any type of reinsurance program, for or on behalf of  
1526 participating members; (6) pool risks among participating members;  
1527 (7) issue policies of insurance on an indemnity or provision of service  
1528 basis providing the coverage required by sections 38a-505, 38a-546 and  
1529 38a-551 to 38a-559, inclusive, in its own name or on behalf of  
1530 participating members; (8) administer separate pools, separate  
1531 accounts or other plans as deemed appropriate for separate members  
1532 or groups of members; (9) operate and administer any combination of  
1533 plans, pools, reinsurance arrangements or other mechanisms as  
1534 deemed appropriate to best accomplish the fair and equitable  
1535 operation of the association; (10) set limits on the amounts of  
1536 reinsurance which may be ceded to the association by its members;  
1537 (11) appoint from among participating members appropriate legal,  
1538 actuarial and other committees as necessary to provide technical  
1539 assistance in the operation of the association, policy and other contract  
1540 design, and any other function within the authority of the association;

1541 and (12) apply for and accept grants, gifts and bequests of funds from  
1542 other states, federal and interstate agencies and independent  
1543 authorities, private firms, individuals and foundations for the purpose  
1544 of carrying out its responsibilities. Any such funds received shall be  
1545 deposited in the General Fund and shall be credited to a separate  
1546 nonlapsing account within the General Fund for the Health  
1547 Reinsurance Association and may be used by the Health Reinsurance  
1548 Association in the performance of its duties.

1549 (c) Every member shall participate in the association in accordance  
1550 with the provisions of this subdivision. (1) A participating member  
1551 shall determine the particular risks it elects to have written by or  
1552 through the association. A member shall designate which of the  
1553 following classes of risks it shall underwrite in the state, from which  
1554 classes of risk it may elect to reinsure selected risks: (A) Individual,  
1555 excluding group conversion; and (B) individual, including group  
1556 conversion. (2) No member shall be permitted to select out individual  
1557 lives from an employer group to be insured by or through the  
1558 association. Members electing to administer risks which are insured by  
1559 or through the association shall comply with the benefit determination  
1560 guidelines and the accounting procedures established by the  
1561 association. A risk insured by or through the association cannot be  
1562 withdrawn by the participating member except in accordance with the  
1563 rules established by the association. (3) Rates for coverage issued by or  
1564 through the association shall not be excessive, inadequate or unfairly  
1565 discriminatory. Separate scales of premium rates based on age shall  
1566 apply, but rates shall not be adjusted for area variations in provider  
1567 costs. Premium rates shall take into consideration the substantial extra  
1568 morbidity and administrative expenses for association risks,  
1569 reimbursement or reasonable expenses incurred for the writing of  
1570 association risks and the level of rates charged by insurers for groups  
1571 of ten lives, provided incurred losses which result from provision of  
1572 coverage in accordance with section 38a-537 shall not be considered. In  
1573 no event shall the rate for a given classification or group be less than  
1574 one hundred twenty-five per cent or more than one hundred fifty per

1575 cent of the average rate charged for that classification with similar  
1576 characteristics under a policy covering ten lives. All rates shall be  
1577 promulgated by the association through an actuarial committee  
1578 consisting of five persons who are members of the American Academy  
1579 of Actuaries, shall be filed with the commissioner and may be  
1580 disapproved within sixty days from the filing thereof if excessive,  
1581 inadequate or unfairly discriminatory.

1582 (d) (1) Following the close of each fiscal year, the administering  
1583 carrier shall determine the net premiums, reinsurance premiums less  
1584 administrative expense allowance, the expense of administration  
1585 pertaining to the reinsurance operations of the association and the  
1586 incurred losses for the year. Any net loss shall be assessed to all  
1587 participating members in proportion to their respective shares of the  
1588 total health insurance premiums earned in this state during the  
1589 calendar year, or with paid losses in the year, coinciding with or  
1590 ending during the fiscal year of the association or on any other  
1591 equitable basis as may be provided in the plan of operations. For self-  
1592 insured members of the association, health insurance premiums  
1593 earned shall be established by dividing the amount of paid health  
1594 losses for the applicable period by eighty-five per cent. Net gains, if  
1595 any, shall be held at interest to offset future losses or allocated to  
1596 reduce future premiums. (2) Any net loss to the association  
1597 represented by the excess of its actual expenses of administering  
1598 policies issued by the association over the applicable expense  
1599 allowance shall be separately assessed to those participating members  
1600 who do not elect to administer their plans. All assessments shall be on  
1601 an equitable formula established by the board. (3) The association shall  
1602 conduct periodic audits to assure the general accuracy of the financial  
1603 data submitted to the association and the association shall have an  
1604 annual audit of its operations by an independent certified public  
1605 accountant. The annual audit shall be filed with the commissioner for  
1606 his review and the association shall be subject to the provisions of  
1607 section 38a-14. (4) For the fiscal year ending December 31, 1993, and  
1608 the first quarter of the fiscal year ending December 31, 1994, the

1609 administering carrier shall not include health care centers in assessing  
1610 any net losses to participating members.

1611 (e) All policy forms issued by or through the association shall  
1612 conform in substance to prototype forms developed by the association,  
1613 shall in all other respects conform to the requirements of sections 38a-  
1614 505, 38a-546 and 38a-551 to 38a-559, inclusive, and shall be approved  
1615 by the commissioner. The commissioner may disapprove any such  
1616 form if it contains a provision or provisions which are unfair or  
1617 deceptive or which encourage misrepresentation of the policy.

1618 (f) Unless otherwise permitted by the plan of operation, the  
1619 association shall not issue, reissue or continue in force comprehensive  
1620 health care plan coverage with respect to any person who is already  
1621 covered under an individual or group comprehensive health care plan,  
1622 or who is sixty-five years of age or older and eligible for Medicare or  
1623 who is not a resident of this state. Coverage provided to a HIPAA or  
1624 health care tax credit eligible individual may be terminated to the  
1625 extent permitted by HIPAA or the Trade Act of 2002, respectively.

1626 (g) Benefits payable under a comprehensive health care plan  
1627 insured by or reinsured through the association shall be paid net of all  
1628 other health insurance benefits paid or payable through any other  
1629 source, and net of all health insurance coverages provided by or  
1630 pursuant to any other state or federal law including Title XVIII of the  
1631 Social Security Act, Medicare, but excluding Medicaid.

1632 (h) There shall be no liability on the part of and no cause of action of  
1633 any nature shall arise against any carrier or its agents or its employees,  
1634 the Health Reinsurance Association or its agents or its employees or  
1635 the residual market mechanism established under the provisions of  
1636 section 38a-557 or its agents or its employees, or the commissioner or  
1637 his representatives for any action taken by them in the performance of  
1638 their duties under sections 38a-505, 38a-546, [and] 38a-551 to 38a-559,  
1639 inclusive, and under sections 3 and 4 of this act. This provision shall  
1640 not apply to the obligations of a carrier, a self-insurer, the Health

1641 Reinsurance Association or the residual market mechanism for  
1642 payment of benefits provided under a comprehensive health care plan.

1643       Sec. 29. (*Effective July 1, 2008*) Notwithstanding the provisions of  
1644 section 4-28e of the general statutes, the sum remaining in the Tobacco  
1645 and Health Trust Fund shall be transferred from said fund to the  
1646 General Fund, of which twenty million dollars shall be used by the  
1647 Department of Public Health for the Connecticut Tobacco Use  
1648 Prevention and Control Plan.

1649       Sec. 30. (*Effective \_\_\_\_*) The sum of \_\_\_\_ dollars is appropriated to  
1650 the Department of Public Health, from the General Fund, for the fiscal  
1651 year ending June 30, \_\_\_\_, to expand the Connecticut Tobacco Use  
1652 Prevention and Control Plan to cover smoking cessation medication  
1653 and supplies, including, but not limited to, nicotine replacement  
1654 therapy.

1655       Sec. 31. (*Effective July 1, 2008*) The sum of one million six hundred  
1656 thousand dollars is appropriated to the Department of Public Health,  
1657 from the General Fund, for the fiscal year ending June 30, 2009, for the  
1658 purpose of providing grants to be awarded on July 1, 2009, in the  
1659 amount of two hundred thousand dollars to eight different groups  
1660 representing the interests of Connecticut employers. The  
1661 Commissioner of Public Health, in accordance with the provisions of  
1662 chapter 54 of the general statutes, shall establish the criteria and  
1663 procedures used to select said groups. Such grants shall be used to  
1664 train employers to effectively educate employees concerning the  
1665 financial and health benefits of making lifestyle choices that promote  
1666 good health, including maintaining a healthy weight and regular  
1667 exercise.

1668       Sec. 32. (*Effective July 1, 2008*) The sum of \_\_\_\_ dollars is  
1669 appropriated to the Department of Social Services, from the General  
1670 Fund, for the fiscal year ending June 30, 2009, for the purposes of  
1671 section 25 of this act.

1672       Sec. 33. (*Effective July 1, 2008*) The sum of one million dollars is  
1673 appropriated to the Department of Social Services, from the General  
1674 Fund, for the fiscal year ending June 30, 2009, for the purpose of  
1675 obtaining consultant services to assist said department in the  
1676 implementation of section 19 of this act.

1677       Sec. 34. (*Effective \_\_\_\_*) The sum of \_\_\_\_ dollars is appropriated to  
1678 the Office of Health Care Access, from the General Fund, for the fiscal  
1679 year ending June 30, \_\_\_\_, for the purposes of section 8 of this act.

1680       Sec. 35. (*Effective \_\_\_\_*) The sum of \_\_\_\_ dollars is appropriated to  
1681 the Office of Health Care Access, from the General Fund, for the fiscal  
1682 year ending June 30, \_\_\_\_, for the purposes of section 9 of this act.

1683       Sec. 36. (*Effective July 1, 2008*) The sum of five hundred thousand  
1684 dollars is appropriated to the Office of Health Care Access, from the  
1685 General Fund, for the fiscal year ending June 30, 2009, for the purposes  
1686 of the Health Care Reform Commission established under section 2 of  
1687 this act.

1688       Sec. 37. (*Effective July 1, 2008*) The sum of five hundred thousand  
1689 dollars is appropriated to the Office of Health Care Access, from the  
1690 General Fund, for the fiscal year ending June 30, 2009, for the purpose  
1691 of providing one-time start-up funds for the establishment of the  
1692 Connecticut Health Quality Partnership pursuant to section 14 of this  
1693 act, which shall be contingent upon the partnership obtaining a  
1694 commitment by six or more members to contribute dues sufficient to  
1695 assure the financial viability of the organization.

1696       Sec. 38. (*Effective July 1, 2008*) The sum of two hundred thousand  
1697 dollars is appropriated to the Office of Health Care Access, from the  
1698 General Fund, for the fiscal year ending June 30, 2009, for the purpose  
1699 of conducting the study and survey as required by section 15 of this  
1700 act.

1701       Sec. 39. (*Effective July 1, 2008*) The sum of \_\_\_\_ dollars is

1702 appropriated to the Office of Health Care Access, from the General  
1703 Fund, for the fiscal year ending June 30, 2009, for the purposes of the  
1704 subcommittee on healthy lifestyles established under section 13 of this  
1705 act.

1706 Sec. 40. (*Effective July 1, 2009*) The sum of \_\_\_\_ dollars is  
1707 appropriated to the Office of Health Care Access, from the General  
1708 Fund, for the fiscal year ending June 30, 2010, for the purposes of the  
1709 subcommittee on healthy lifestyles established under section 13 of this  
1710 act.

1711 Sec. 41. (*Effective July 1, 2008*) The sum of one million dollars is  
1712 appropriated to the Insurance Department, from the General Fund, for  
1713 the fiscal year ending June 30, 2009, for the purpose of providing start-  
1714 up costs for the Connecticut Connector including, but not limited to,  
1715 web site development, a premium subsidy administration system,  
1716 marketing, communications, administrative functions, and purchase of  
1717 other technology and equipment to facilitate and streamline operation  
1718 and administration of the Connecticut Connector.

1719 Sec. 42. (*Effective July 1, 2008*) (a) The sum of \_\_\_\_ dollars is  
1720 appropriated to the Insurance Department, from the General Fund, for  
1721 the fiscal year ending June 30, 2009, to operate and administer the  
1722 Connecticut Connector, and to market the affordable health care plans.

1723 (b) The sum of \_\_\_\_ dollars is appropriated to the Insurance  
1724 Department, from the General Fund, for the fiscal year ending June 30,  
1725 2010, to operate and administer the Connecticut Connector, and to  
1726 market the affordable health care plans.

1727 Sec. 43. Section 17b-261c of the general statutes is repealed. (*Effective*  
1728 *January 1, 2009*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2008</i>	New section

Sec. 2	<i>July 1, 2008</i>	New section
Sec. 3	<i>July 1, 2008</i>	New section
Sec. 4	<i>March 1, 2010</i>	New section
Sec. 5	<i>January 1, 2010</i>	New section
Sec. 6	<i>March 1, 2010</i>	New section
Sec. 7	<i>October 1, 2008</i>	New section
Sec. 8	<i>October 1, 2009</i>	New section
Sec. 9	<i>October 1, 2009</i>	New section
Sec. 10	<i>January 1, 2009</i>	38a-567
Sec. 11	<i>July 1, 2008</i>	New section
Sec. 12	<i>July 1, 2008</i>	New section
Sec. 13	<i>January 1, 2009</i>	New section
Sec. 14	<i>July 1, 2008</i>	New section
Sec. 15	<i>October 1, 2008</i>	New section
Sec. 16	<i>July 1, 2008</i>	New section
Sec. 17	<i>July 1, 2008</i>	New section
Sec. 18	_____	New section
Sec. 19	<i>July 1, 2008</i>	New section
Sec. 20	<i>July 1, 2008</i>	New section
Sec. 21	<i>July 1, 2008</i>	New section
Sec. 22	<i>July 1, 2008</i>	17b-192(a)
Sec. 23	<i>July 1, 2008</i>	17b-261
Sec. 24	<i>July 1, 2008</i>	17b-292
Sec. 25	<i>July 1, 2009</i>	17b-267
Sec. 26	<i>July 1, 2008</i>	New section
Sec. 27	<i>January 1, 2010, and applicable to income years commencing on or after January 1, 2010</i>	New section
Sec. 28	<i>July 1, 2008</i>	38a-556
Sec. 29	<i>July 1, 2008</i>	New section
Sec. 30	_____	New section
Sec. 31	<i>July 1, 2008</i>	New section
Sec. 32	<i>July 1, 2008</i>	New section
Sec. 33	<i>July 1, 2008</i>	New section
Sec. 34	_____	New section
Sec. 35	_____	New section
Sec. 36	<i>July 1, 2008</i>	New section
Sec. 37	<i>July 1, 2008</i>	New section
Sec. 38	<i>July 1, 2008</i>	New section

Sec. 39	<i>July 1, 2008</i>	New section
Sec. 40	<i>July 1, 2009</i>	New section
Sec. 41	<i>July 1, 2008</i>	New section
Sec. 42	<i>July 1, 2008</i>	New section
Sec. 43	<i>January 1, 2009</i>	Repealer section

***Statement of Purpose:***

To reduce the number of Connecticut residents without health insurance, reduce the cost of health benefits, promote the health of Connecticut residents, and improve the quality of health care services in the state.

*[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]*