



General Assembly

Substitute Bill No. 5721

February Session, 2008

* HB05721INS 031308 *

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 and 27 of this act, and subsection (a) of section
3 17b-192 of the 2008 supplement to the general statutes, section 17b-261
4 of the 2008 supplement to the general statutes, section 17b-267 of the
5 general statutes, section 17b-292 of the 2008 supplement to the general
6 statutes, and section 38a-567 of the general statutes, as amended by
7 this act, shall be known as the Connecticut Healthy Steps program.

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

20 appointed by the speaker of the House of Representatives; and three
21 by the Governor, one of whom shall be an owner of a Connecticut
22 business with fifty or fewer employees in the state, one of whom shall
23 be an owner, senior manager or human resources director of a
24 Connecticut business with more than fifty employees in the state, and
25 one of whom shall be a senior manager or human resources director of
26 a labor union that offers a Taft-Hartley plan.

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

44 (c) The commission shall:

45 (1) (A) Notwithstanding section 38a-553 of the general statutes, not
46 later than April 1, 2009, design health benefit plans that shall be known
47 as affordable health care plans that meet the requirements of section 4
48 of this act and that shall be approved by the Insurance Commissioner,
49 (B) not later than January 1, 2010, make such plans available for sale,
50 and if any employer purchases such plan for its employees through the
51 Connecticut Connector, as defined in section 3 of this act, or any other
52 plan through the Connecticut Connector for its employees that is at

53 least equivalent to the type and level of benefits of affordable health
54 care plans, such employer shall qualify for a tax credit pursuant to
55 section 27 of this act, and (C) adopt rules for the collection of fees in
56 accordance with subdivision (4) of subsection (d) of section 3 of this
57 act;

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

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

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

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

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

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

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

80 (9) Not later than January 1, 2010, and annually thereafter, make
81 recommendations to the General Assembly concerning the
82 implementation of the Connecticut Healthy Steps program and

83 improvements to the health care system, including cost controls.

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

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

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

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

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

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

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

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

111 (3) Make payments to agents for referrals of small employers and

112 individuals that qualify for and purchase affordable health care plans;

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

130 (5) Provide notices as required under the Health Insurance
131 Portability and Accountability Act of 1996, P.L. 104-191, as amended
132 from time to time, 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; (B) assisted by
160 the commission, process applications submitted for individual
161 insurance; (C) publish easy to understand materials for prospective
162 purchasers, comparing the costs and benefits of all plans to assist in
163 plan selection; (D) assist applicants to understand the benefits offered
164 under the plans and assist in selecting a plan that reflects the need and
165 income of the applicant, except that such assistance shall not be
166 deemed to require an insurance agent license; (E) work with the
167 insurers selling products through the Connecticut Connector to
168 develop and adopt a uniform tool approved by the Insurance
169 Commissioner for collecting necessary applicant or enrollee data for
170 any appropriate underwriting, enrollment and other purposes; (F)
171 collect premium contributions from employers and individuals, as well
172 as subsidies from the state, and remit them to enrollees' health plans;
173 (G) notify insureds when their premiums are late and disenroll them
174 or levy late penalties in accordance with the provisions of section 38a-
175 483 of the general statutes; and (H) provide information regarding
176 Health Reinsurance Association benefits to applicants who are denied

177 coverage due to underwriting concerns;

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

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

198 (b) Such plans shall include: (1) Minimum benefits as follows: (A)
199 Coverage of physician, clinic, ambulatory surgery, laboratory and
200 diagnostic service, in-patient and out-patient hospital care and
201 prescription drugs that are medically necessary, as defined in
202 subsection (a) of section 38a-482a of the 2008 supplement to the general
203 statutes, for physical or mental health; (B) out-of-pocket costs
204 including, but not limited to, copayments, deductibles and coinsurance
205 that shall reflect the following family income brackets: (i) Family
206 income that is less than two hundred per cent of the federal poverty
207 level, (ii) family income that is equal to or greater than two hundred
208 per cent but less than three hundred per cent of the federal poverty
209 level, (iii) family income that is greater than three hundred per cent but

210 less than four hundred per cent of the federal poverty level, and (iv)
211 family income that is greater than four hundred per cent of the federal
212 poverty level; (C) no deductible for well-child visits, prenatal care and
213 the first two physician visits annually; (D) a lifetime benefits maximum
214 in an amount not less than five hundred thousand dollars, contingent
215 upon availability of an excess cost reinsurance program established by
216 the Department of Social Services as provided in section 18 of this act.
217 In the event such excess cost reinsurance program is not available, the
218 lifetime benefits maximum shall be in an amount not less than one
219 million dollars.

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

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

233 (e) Such individual plans shall have a minimum loss ratio of not less
234 than seventy-five per cent for individual health care plans over any
235 three-year moving average period, provided "loss", for the purposes of
236 such term, shall not include administrative activities including, but not
237 limited to, enrollment, marketing, premium collection, claims
238 adjudication, member services and profit.

239 (f) With respect to an applicant for an individual affordable health
240 care plan with an identified preexisting condition, an insurer or health
241 care center offering individual insurance coverage through the

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

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

265 (h) The affordable health care plans offered by the Connecticut
266 Connector to small employers shall have premium rates established on
267 the basis of a community rate in accordance with the provisions of
268 subdivision (5) of section 38a-567 of the general statutes, as amended
269 by this act.

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

272 (j) Any employer that purchases an affordable health care plan
273 through the Connecticut Connector may offer its employees only that

274 plan or may offer such plan as a choice among an array of
275 comprehensive plans or a high deductible health plan issued with a
276 health savings account. In the event an employer offers plans in
277 addition to the affordable health care plan, such employer may offer
278 the same percentage or dollar contribution for all plans if such
279 employer allows its employees to select a plan.

280 Sec. 5. (NEW) (*Effective January 1, 2010*) (a) An application by an
281 individual, who can show proof of residency in the state, to purchase
282 coverage through the Connecticut Connector, as defined in section 3 of
283 this act, may be approved in cases in which such individual has no
284 access to employer-sponsored coverage under which the employer
285 pays a minimum of fifty per cent of the cost of such coverage for an
286 individual and his or her dependents and such individual has been
287 either: (1) Uninsured for a period of at least six months; or (2)
288 uninsured for a period of less than six months due to the occurrence of
289 a major life event that has resulted in such uninsured status, including,
290 but not limited to, (A) loss of coverage through the employer, due to
291 termination of employment, (B) death of, or abandonment by, a family
292 member through whom coverage was previously provided, (C) loss of
293 dependent coverage when the individual's spouse became Medicare
294 eligible due to age or disability, (D) loss of coverage as a dependent
295 under any group health insurance policy providing coverage of the
296 type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section
297 38a-469 of the general statutes due to age, divorce or other changes in
298 status, (E) expiration of the coverage periods established by the
299 Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272,
300 as amended from time to time, (F) extreme economic hardship on the
301 part of either the employee or the employer, as determined by the
302 organization that administers the Connecticut Connector, in
303 accordance with specific measurable criteria defined by the
304 commission, and (G) any other events that may be specified by the
305 commission. For purposes of this subsection, "proof of residency"
306 means evidence of domicile in the state such as voter registration, tax
307 filings, utility bill or other documentation deemed satisfactory by the

308 Insurance Commissioner.

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

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

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

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

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

328 (D) "Individual" means a natural person provided coverage under
329 an individual health insurance policy that has been approved by the
330 Insurance Department who is deemed to be the policyholder;

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

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

335 (G) "Plan of operation" means the plan of operation of the pool,
336 including articles, bylaws and operating rules, adopted by the board

337 pursuant to subdivision (3) of this subsection;

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

340 (2) There is established a nonprofit entity which shall be known as
341 the "Connecticut Individual Health Reinsurance Pool". All insurers
342 issuing health insurance in this state on and after March 1, 2010, shall
343 be members of the pool. The board of directors of the Connecticut
344 Small Employer Health Reinsurance Pool established under section
345 38a-569 of the general statutes shall administer the pool.

346 (3) Not later than ninety days after March 1, 2010, the board shall
347 submit to the commissioner a plan of operation and, thereafter, any
348 amendments thereto necessary or suitable to assure the fair, reasonable
349 and equitable administration of the pool. The commissioner shall, after
350 notice and hearing, approve the plan of operation, provided the
351 commissioner determines it to be suitable to assure the fair, reasonable
352 and equitable administration of the pool, and provides for the sharing
353 of pool gains or losses on an equitable proportionate basis in
354 accordance with the provisions of subsection (d) of this section. The
355 plan of operation shall become effective upon approval, in writing, by
356 the commissioner consistent with the date on which the coverage
357 under this section shall be made available. If the board fails to submit a
358 suitable plan of operation not later than one hundred eighty days after
359 March 1, 2010, or at any time thereafter fails to submit suitable
360 amendments to the plan of operation, the commissioner shall, after
361 notice and hearing, adopt and promulgate a plan of operation or
362 amendments, as appropriate. The commissioner shall amend any plan
363 adopted, as necessary, at the time a plan of operation is submitted by
364 the board and approved by the 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 of
419 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 approved by the Secretary of Health and Human Services as a health
450 maintenance organization pursuant to 42 USC 300e et seq., subject to
451 an assessment adjustment formula adopted by the board and
452 approved by the commissioner for such health care centers, that
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 shall 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 amended
537 from time to time, 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
540 who has contributed or received contributions of at least two thousand
541 five hundred dollars in his or her health savings account in the
542 previous year; one thousand dollars for a family of two who has
543 contributed or received contributions of at least three thousand seven
544 hundred fifty dollars in their health savings account in the previous
545 year; or one thousand five hundred dollars for a family of three or
546 more who has contributed or received contributions of at least five
547 thousand dollars 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 health insurance premium subsidy program. To be eligible for
573 payment pursuant to this section, an individual (1) shall not have
574 family income greater than three hundred per cent of the federal
575 poverty level, (2) shall not individually or as part of a family own a
576 health savings account pursuant to section 223 of the Internal Revenue
577 Code of 1986, or any subsequent corresponding internal revenue code
578 of the United States, as amended from time to time, and (3) shall have
579 an affordable health care plan purchased through the Connecticut
580 Connector, as defined in section 3 of this act, or any group health
581 insurance policy providing coverage of the type specified in
582 subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 of the
583 general statutes for which the employee pays at least five hundred
584 dollars in premiums annually to the employee's employer if single and
585 at least one thousand dollars in premiums annually to the employee's
586 employer if the employee is covered by a family plan or under a
587 nonemployer-based plan purchased through the individual market or
588 the Connecticut Connector. The Connecticut Connector shall quarterly
589 reimburse an individual who is eligible pursuant to this section for
590 premiums paid 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)] P.L. 99-2721, as amended from time
688 to time, or other applicable laws. The employee or dependent must
689 request coverage under the new plan or arrangement on a timely basis
690 and such coverage shall terminate in accordance with the provisions of
691 the applicable law.

692 (3) (A) For rating periods commencing on or after October 1, 1993,

693 and prior to July 1, 1994, the premium rates charged or offered for a
694 rating period for all plans and arrangements may not exceed one
695 hundred thirty-five per cent of the base premium rate for all plans or
696 arrangements.

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

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

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

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

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

721 (5) (A) With respect to plans or arrangements delivered, issued for
722 delivery, renewed, amended or continued in this state on or after [July
723 1, 1995] January 1, 2009, the premium rates charged or offered to small

724 employers shall be established on the basis of a community rate,
725 adjusted to reflect one or more of the following classifications:

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

728 (ii) Gender;

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

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

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

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

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

752 (viii) Family composition, provided the small employer carrier shall
753 utilize only one or more of the following billing classifications: (I)

754 Employee; (II) employee plus family; (III) employee and spouse; (IV)
755 employee and child; (V) employee plus one dependent; and (VI)
756 employee plus two or more dependents; and

757 (ix) Participation in a nonsmoking program that complies with the
758 Health Insurance Portability and Accountability Act of 1996, P.L. 104-
759 191, as amended from time to time.

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

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

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

784 (7) For rating periods commencing prior to July 1, 1995, in any case
785 where a small employer carrier utilized industry classification as a case

786 characteristic in establishing premium rates, the rate factor associated
787 with any industry classification shall not vary from the arithmetical
788 average of the highest and lowest rate factors associated with all
789 industry classifications by greater than fifteen per cent of such average.

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

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

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

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

814 (A) Encouraging or directing small employers to refrain from filing
815 an application for coverage with the small employer carrier because of
816 the health status, claims experience, industry, occupation or
817 geographic location of the small employer, except the provisions of

818 this subparagraph shall not apply to information provided by a small
819 employer carrier or producer to a small employer regarding the
820 carrier's established geographic service area or a restricted network
821 provision of a small employer carrier; or

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

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

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

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

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

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

855 (17) The commissioner may adopt regulations_z in accordance with
856 the provisions of chapter 54_z setting forth additional standards to
857 provide for the fair marketing and broad availability of health benefit
858 plans to small employers.

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

881 (19) The commissioner may suspend all or any part of this section
882 relating to the premium rates applicable to one or more small

883 employers for one or more rating periods upon a filing by the small
884 employer carrier and a finding by the commissioner that either the
885 suspension is reasonable in light of the financial condition of the
886 carrier or that the suspension would enhance the efficiency and
887 fairness of the marketplace for small employer health insurance.

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

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

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

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

915 state and partial payment of educational loans.

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

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

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

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

938 Sec. 14. (NEW) (*Effective July 1, 2008*) (a) Not later than July 1, 2009,
939 the Health Care Reform Commission, established under section 2 of
940 this act, shall establish the Connecticut Health Quality Partnership.
941 The members of the partnership shall be appointed by the
942 Commissioner of Health Care Access, and shall consist of a minimum
943 of eight representatives from both the private and public sectors,
944 including, but not limited to, health insurers, hospital associations, a
945 representative of physicians, the Commissioners of Public Health and
946 Social Services or their designees, representatives of Medicaid

947 managed care organizations and not more than two consumer
948 advocates who are not otherwise affiliated with any other members.
949 The commission shall assign staff to assist the partnership with its
950 responsibilities.

951 (b) The Connecticut Health Quality Partnership shall: (1) Be
952 responsible for collecting and analyzing insurance and Medicaid
953 claims data and other data concerning the quality of care and services
954 provided by health care providers, for the purpose of supporting
955 quality improvement initiatives and enabling consumers to make
956 informed choices with respect to such health care providers; (2)
957 provide comparative data to health care providers concerning the
958 quality of their performance relative to their peers; (3) be responsible
959 for collecting and analyzing data from hospitals pertaining to
960 nosocomial infections for the purpose of tracking, reporting and
961 reducing nosocomial infection rates; (4) be responsible for collecting
962 and analyzing such data from other health care providers, as it deems
963 necessary; (5) be responsible for annually selecting state-wide quality
964 improvement initiatives and encouraging all health plans to adopt
965 such quality improvement initiatives with the same goals and metrics;
966 (6) seek funding from private and federal funding sources; and (7) seek
967 accreditation not later than July 1, 2013, by the National Committee for
968 Quality Assurance as a Quality Plus program.

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

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

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

992 (b) Not later than September 1, 2009, the Commissioner of Public
993 Health shall submit a report, in accordance with section 11-4a of the
994 general statutes, of findings and recommendations to the joint
995 standing committees of the General Assembly having cognizance of
996 matters relating to public health and appropriations and the budgets of
997 state agencies. Such report shall identify the programs that are likely to
998 experience a decrease in utilization due to the implementation of the
999 programs and plans established under the Connecticut Healthy Steps
1000 program and the amount of such decrease, to the extent feasible.

1001 Sec. 17. (NEW) (*Effective July 1, 2008*) The Office of Health Care
1002 Access shall utilize the data obtained pursuant to section 15 of this act
1003 relative to any decreases in the number of uninsured residents of this
1004 state to make recommendations to the Department of Social Services
1005 for commensurate decreases in the disproportionate share payments to
1006 hospitals in accordance with the provisions of section 19a-671 of the
1007 2008 supplement to the general statutes.

1008 Sec. 18. (NEW) (*Effective July 1, 2008*) The Commissioner of Social
1009 Services shall establish an excess cost reinsurance program to carry out
1010 the provisions of subparagraph (D) of subdivision (1) of subsection (b)
1011 of section 4 of this act. Such program shall (1) disregard assets equal to
1012 the amount of insurance premium payments paid by an insured for an

1013 affordable health care plan for the two years prior to Medicaid
1014 application, and (2) disregard as income the amount of insurance
1015 premium payments made by an insured for an affordable health care
1016 plan in the year of Medicaid application. Said commissioner may
1017 adopt regulations, in accordance with chapter 54 of the general
1018 statutes, to implement the requirements of this section.

1019 Sec. 19. (NEW) (*Effective July 1, 2008*) Not later than December 31,
1020 2008, the Commissioner of Social Services shall seek a waiver or
1021 waivers of federal Medicaid rules for the purposes of (1) obtaining any
1022 available federal reimbursement, including federal financial
1023 participation, for state expenditures related to the health savings
1024 account incentive program established under section 8 of this act and
1025 the premium subsidy program established under section 9 of this act,
1026 and (2) establishing a state excess cost reinsurance program for
1027 enrollees in the Connecticut Connector's affordable health care plan to
1028 allow such enrollees to obtain coverage through the Medicaid program
1029 once their insurance benefits are exhausted without having to spend
1030 down their assets.

1031 Sec. 20. (NEW) (*Effective July 1, 2008*) (a) The Commissioner of Social
1032 Services shall develop a plan to improve the coordination of the
1033 delivery of health care services to all or a substantial subset of the
1034 aged, blind and disabled Medicaid beneficiaries. Such plan shall
1035 include programs to (1) improve coordination of and access to medical
1036 services, social services and housing, (2) implement chronic disease
1037 management programs, (3) use predictive modeling to identify high
1038 risk, complex and high-cost Medicaid beneficiaries, and (4) provide
1039 such beneficiaries with intensive clinical care coordination and
1040 pharmacological management. The commissioner may contract with
1041 an administrative services organization to effectuate the
1042 implementation of such plan.

1043 (b) Such plan shall also address: (1) Provider reimbursement
1044 systems that are aligned with the goal of managing the care of
1045 individuals who have, or are at risk for having, chronic health

1046 conditions in order to improve health outcomes and the quality of care
1047 for such individuals; and (2) the use and development of outcome
1048 measures and reporting requirements, aligned with existing outcome
1049 measures within the Department of Social Services, to assess and
1050 evaluate the system of chronic care.

1051 (c) Not later than January 1, 2009, the Commissioner of Social
1052 Services shall submit such plan, in accordance with section 11-4a of the
1053 general statutes, to the joint standing committees of the General
1054 Assembly having cognizance of matters relating to human services and
1055 appropriations and the budgets of state agencies. On October 1, 2010,
1056 and annually thereafter, the Commissioner of Social Services shall
1057 report, in accordance with the provisions of section 11-4a of the general
1058 statutes, on the status of implementation of such plan to the joint
1059 standing committees of the General Assembly having cognizance of
1060 matters relating to human services and appropriations and the budgets
1061 of state agencies. The report shall include the number of individuals
1062 and health care providers participating in the programs specified in
1063 subsection (a) of this section, indicators of quality improvement and
1064 patient satisfaction, annual expenditures and savings associated with
1065 the plan and such other information as may be requested by said joint
1066 standing committees.

1067 Sec. 21. (NEW) (*Effective July 1, 2008*) On and after January 1, 2009,
1068 the Commissioner of Social Services shall allow aged, blind or disabled
1069 Medicaid beneficiaries to voluntarily enroll in the managed care plans
1070 available to HUSKY Plan, Part A and HUSKY Plan, Part B
1071 beneficiaries.

1072 Sec. 22. Subsection (a) of section 17b-192 of the 2008 supplement to
1073 the general statutes is repealed and the following is substituted in lieu
1074 thereof (*Effective July 1, 2008*):

1075 (a) The Commissioner of Social Services shall implement a state
1076 medical assistance component of the state-administered general
1077 assistance program for persons ineligible for Medicaid. Eligibility

1078 criteria concerning income shall be the same as the medically needy
1079 component of the Medicaid program as utilized on June 30, 2008,
1080 except that earned monthly gross income of up to one hundred fifty
1081 dollars shall be disregarded. Unearned income shall not be
1082 disregarded. No person who has family assets exceeding one thousand
1083 dollars shall be eligible. No person shall be eligible for assistance
1084 under this section if such person made, during the three months prior
1085 to the month of application, an assignment or transfer or other
1086 disposition of property for less than fair market value. The number of
1087 months of ineligibility due to such disposition shall be determined by
1088 dividing the fair market value of such property, less any consideration
1089 received in exchange for its disposition, by five hundred dollars. Such
1090 period of ineligibility shall commence in the month in which the
1091 person is otherwise eligible for benefits. Any assignment, transfer or
1092 other disposition of property, on the part of the transferor, shall be
1093 presumed to have been made for the purpose of establishing eligibility
1094 for benefits or services unless such person provides convincing
1095 evidence to establish that the transaction was exclusively for some
1096 other purpose.

1097 Sec. 23. Section 17b-261 of the 2008 supplement to the general
1098 statutes is amended by adding subsections (j) and (k) as follows
1099 (*Effective July 1, 2008*):

1100 (NEW) (j) Notwithstanding the provisions of this section, the
1101 Commissioner of Social Services, pursuant to 42 USC 1396a(r)(2), shall
1102 file an amendment to the Medicaid state plan that allows said
1103 commissioner, when making Medicaid income eligibility
1104 determinations, to establish a special income disregard applicable only
1105 to the Medicaid program that permits individuals who are aged, blind
1106 or disabled and who have income that is not greater than one hundred
1107 per cent of the federal poverty level to qualify for Medicaid.

1108 (NEW) (k) To the extent permitted by federal law, the
1109 Commissioner of Social Services may impose copayments on persons
1110 eligible for medical assistance under the provisions of this section who

1111 utilize the emergency room of a hospital to access services of a
1112 nonemergency nature. Services of a nonemergency nature shall be
1113 defined by the commissioner after consultation with representative
1114 staff of emergency rooms throughout the state. Prior to imposing any
1115 such copayments, the commissioner shall provide not less than thirty
1116 days written notice to all persons eligible for medical assistance under
1117 this section advising such persons of the impending implementation of
1118 copayments and the Department of Social Services' policies that will be
1119 applicable to such copayments. The first instance of emergency room
1120 use by an eligible person to access services of a nonemergency nature
1121 shall not result in the imposition of a copayment, but the staff at such
1122 emergency room shall provide verbal and written notice, in a manner
1123 prescribed by the commissioner, that advises such person that
1124 continued use of the emergency room for services of a nonemergency
1125 nature shall result in the imposition of copayments on the recipient
1126 and that such person should seek nonemergency care from other
1127 providers assigned to provide medical assistance to such person in
1128 accordance with the provisions of this section. Any copayment
1129 imposed pursuant to this subsection shall not exceed the sum of
1130 twenty-five dollars per visit and the hospital shall have the discretion
1131 to waive collection of the copayment based on a determination of
1132 hardship or otherwise. The commissioner shall not deduct any
1133 copayment imposed pursuant to this subsection from payments that
1134 are due and owing from the department to such emergency room.

1135 Sec. 24. Section 17b-292 of the 2008 supplement to the general
1136 statutes is repealed and the following is substituted in lieu thereof
1137 (*Effective July 1, 2008*):

1138 (a) A child who resides in a household with a family income which
1139 exceeds one hundred eighty-five per cent of the federal poverty level
1140 and does not exceed three hundred per cent of the federal poverty
1141 level may be eligible for subsidized benefits under the HUSKY Plan,
1142 Part B.

1143 (b) A child who resides in a household with a family income over

1144 three hundred per cent of the federal poverty level may be eligible for
1145 unsubsidized benefits under the HUSKY Plan, Part B.

1146 (c) Whenever a court or family support magistrate orders a
1147 noncustodial parent to provide health insurance for a child, such
1148 parent may provide for coverage under the HUSKY Plan, Part B.

1149 (d) On and after January 1, 2009, a child who is determined to be
1150 eligible for benefits under either the HUSKY Plan, Part A or Part B,
1151 shall remain eligible for such plan for a period of twelve months from
1152 such child's determination of eligibility unless the child attains the age
1153 of nineteen or is no longer a resident of the state. An adult who is
1154 determined to be eligible for benefits under the HUSKY Plan, Part A
1155 shall, unless otherwise precluded under federal law, remain eligible
1156 for such plan for a period of twelve months from such adult's
1157 determination of eligibility unless the adult is no longer a resident of
1158 the state. During the twelve-month period following the date that an
1159 adult or child is determined eligible for the HUSKY Plan, Part A or
1160 Part B, the adult or family of such child shall comply with federal
1161 requirements concerning the reporting of information to the
1162 department, including, but not limited to, change of address
1163 information.

1164 [(d)] (e) To the extent allowed under federal law, the commissioner
1165 shall not pay for services or durable medical equipment under the
1166 HUSKY Plan, Part B if the enrollee has other insurance coverage for
1167 the services or such equipment.

1168 [(e)] (f) A newborn child who otherwise meets the eligibility criteria
1169 for the HUSKY Plan, Part B shall be eligible for benefits retroactive to
1170 his or her date of birth, provided an application is filed on behalf of the
1171 child not later than thirty days after such date. Any uninsured child
1172 born in a hospital in this state or in a border state hospital shall be
1173 enrolled on an expedited basis in the HUSKY Plan, Part B, provided (1)
1174 the parent or caretaker relative of such child resides in this state, and
1175 (2) the parent or caretaker relative of such child authorizes enrollment

1176 in the program. The commissioner shall pay any premium cost such
1177 family would otherwise incur for the first four months of coverage to
1178 the managed care organization selected by the parent or caretaker
1179 relative to provide coverage for such child.

1180 ~~[(f)]~~ (g) The commissioner shall implement presumptive eligibility
1181 for children applying for Medicaid. Such presumptive eligibility
1182 determinations shall be in accordance with applicable federal law and
1183 regulations. The commissioner shall adopt regulations, in accordance
1184 with chapter 54, to establish standards and procedures for the
1185 designation of organizations as qualified entities to grant presumptive
1186 eligibility. Qualified entities shall ensure that, at the time a
1187 presumptive eligibility determination is made, a completed application
1188 for Medicaid is submitted to the department for a full eligibility
1189 determination. In establishing such standards and procedures, the
1190 commissioner shall ensure the representation of state-wide and local
1191 organizations that provide services to children of all ages in each
1192 region of the state.

1193 ~~[(g)]~~ (h) The commissioner shall provide for a single point of entry
1194 servicer for applicants and enrollees under the HUSKY Plan, Part A
1195 and Part B. The commissioner, in consultation with the servicer, shall
1196 establish a centralized unit to be responsible for processing all
1197 applications for assistance under the HUSKY Plan, Part A and Part B.
1198 The department, through its servicer, shall ensure that a child who is
1199 determined to be eligible for benefits under the HUSKY Plan, Part A,
1200 or the HUSKY Plan, Part B has uninterrupted health insurance
1201 coverage for as long as the parent or guardian elects to enroll or re-
1202 enroll such child in the HUSKY Plan, Part A or Part B. The
1203 commissioner, in consultation with the servicer, and in accordance
1204 with the provisions of section 17b-297 of the 2008 supplement to the
1205 general statutes, shall jointly market both Part A and Part B together as
1206 the HUSKY Plan and shall develop and implement public information
1207 and outreach activities with community programs. Such servicer shall
1208 electronically transmit data with respect to enrollment and
1209 disenrollment in the HUSKY Plan, Part A and Part B to the

1210 commissioner.

1211 [(h)] (i) Upon the expiration of any contractual provisions entered
1212 into pursuant to subsection [(g)] (h) of this section, the commissioner
1213 shall develop a new contract for single point of entry services and
1214 managed care enrollment brokerage services. The commissioner may
1215 enter into one or more contractual arrangements for such services for a
1216 contract period not to exceed seven years. Such contracts shall include
1217 performance measures, including, but not limited to, specified time
1218 limits for the processing of applications, parameters setting forth the
1219 requirements for a completed and reviewable application and the
1220 percentage of applications forwarded to the department in a complete
1221 and timely fashion. Such contracts shall also include a process for
1222 identifying and correcting noncompliance with established
1223 performance measures, including sanctions applicable for instances of
1224 continued noncompliance with performance measures.

1225 [(i)] (j) The single point of entry servicer shall send all applications
1226 and supporting documents to the commissioner for determination of
1227 eligibility. The servicer shall enroll eligible beneficiaries in the
1228 applicant's choice of managed care plan. Upon enrollment in a
1229 managed care plan, an eligible HUSKY Plan Part A or Part B
1230 beneficiary shall remain enrolled in such managed care plan for twelve
1231 months from the date of such enrollment unless (1) an eligible
1232 beneficiary demonstrates good cause to the satisfaction of the
1233 commissioner of the need to enroll in a different managed care plan, or
1234 (2) the beneficiary no longer meets program eligibility requirements.

1235 [(j)] (k) Not later than ten months after the determination of
1236 eligibility for benefits under the HUSKY Plan, Part A and Part B and
1237 annually thereafter, the commissioner or the servicer, as the case may
1238 be, shall within existing budgetary resources, mail or, upon request of
1239 a participant, electronically transmit an application form to each
1240 participant in the plan for the purposes of obtaining information to
1241 make a determination on continued eligibility beyond the twelve
1242 months of initial eligibility. To the extent permitted by federal law, in

1243 determining eligibility for benefits under the HUSKY Plan, Part A or
1244 Part B with respect to family income, the commissioner or the servicer
1245 shall rely upon information provided in such form by the participant
1246 unless the commissioner or the servicer has reason to believe that such
1247 information is inaccurate or incomplete. The Department of Social
1248 Services shall annually review a random sample of cases to confirm
1249 that, based on the statistical sample, relying on such information is not
1250 resulting in ineligible clients receiving benefits under HUSKY Plan
1251 Part A or Part B. The determination of eligibility shall be coordinated
1252 with health plan open enrollment periods.

1253 [(k)] (l) The commissioner shall implement the HUSKY Plan, Part B
1254 while in the process of adopting necessary policies and procedures in
1255 regulation form in accordance with the provisions of section 17b-10.

1256 [(l)] (m) The commissioner shall adopt regulations, in accordance
1257 with chapter 54, to establish residency requirements and income
1258 eligibility for participation in the HUSKY Plan, Part B and procedures
1259 for a simplified mail-in application process. Notwithstanding the
1260 provisions of section 17b-257b, such regulations shall provide that any
1261 child adopted from another country by an individual who is a citizen
1262 of the United States and a resident of this state shall be eligible for
1263 benefits under the HUSKY Plan, Part B upon arrival in this state.

1264 Sec. 25. Section 17b-267 of the general statutes is repealed and the
1265 following is substituted in lieu thereof (*Effective July 1, 2009*):

1266 (a) If any group or association of providers of medical assistance
1267 services wishes to have payments as provided for under sections 17b-
1268 260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to
1269 17b-361, inclusive, to such providers made through a national, state or
1270 other public or private agency or organization and nominates such
1271 agency or organization for this purpose, the Commissioner of Social
1272 Services is authorized to enter into an agreement with such agency or
1273 organization providing for the determination by such agency or
1274 organization, subject to such review by the Commissioner of Social

1275 Services as may be provided for by the agreement, of the payments
1276 required to be made to such providers at the rates set by the hospital
1277 cost commission, and for the making of such payments by such agency
1278 or organization to such providers. Such agreement may also include
1279 provision for the agency or organization to do all or any part of the
1280 following: With respect to the providers of services which are to
1281 receive payments through it, (1) to serve as a center for, and to
1282 communicate to providers, any information or instructions furnished
1283 to it by the Commissioner of Social Services, and to serve as a channel
1284 of communication from providers to the Commissioner of Social
1285 Services; (2) to make such audits of the records of providers as may be
1286 necessary to insure that proper payments are made under this section;
1287 and (3) to perform such other functions as are necessary to carry out
1288 the provisions of sections 17b-267 to 17b-271, inclusive, as amended by
1289 this act.

1290 (b) The Commissioner of Social Services shall not enter into an
1291 agreement with any agency or organization under subsection (a) of
1292 this section unless (1) he finds (A) that to do so is consistent with the
1293 effective and efficient administration of the medical assistance
1294 program, and (B) that such agency or organization is willing and able
1295 to assist the providers to which payments are made through it in the
1296 application of safeguards against unnecessary utilization of services
1297 furnished by them to individuals entitled to hospital insurance benefits
1298 under section 17b-261 of the 2008 supplement to the general statutes,
1299 as amended by this act, and the agreement provides for such
1300 assistance, and (2) such agency or organization agrees to furnish to the
1301 Commissioner of Social Services such of the information acquired by it
1302 in carrying out its agreement under sections 17b-267 to 17b-271,
1303 inclusive, as amended by this act, as the Commissioner of Social
1304 Services may find necessary in performing his functions under said
1305 sections.

1306 (c) An agreement with any agency or organization under subsection
1307 (a) of this section may contain such terms and conditions as the
1308 Commissioner of Social Services finds necessary or appropriate, may

1309 provide for advances of funds to the agency or organization for the
1310 making of payments by it under said subsection (a), and shall provide
1311 for payment by the Commissioner of Social Services of so much of the
1312 cost of administration of the agency or organization as is determined
1313 by the Commissioner of Social Services to be necessary and proper for
1314 carrying out the functions covered by the agreement.

1315 (d) Each managed care plan that enters into, renews or amends a
1316 contract with the Department of Social Services pursuant to this
1317 section shall limit its administrative costs to ten per cent of payments
1318 made pursuant to such contracts. The Commissioner of Social Services
1319 shall implement policies and procedures to effectuate the purpose of
1320 this subsection while in the process of adopting such policies or
1321 procedures in regulation form, provided notice of intention to adopt
1322 the regulations is printed in the Connecticut Law Journal not later than
1323 twenty days after implementation and any such policies and
1324 procedures shall be valid until the time the regulations are effective.
1325 The Commissioner of Social Services may define administrative costs
1326 to exclude disease management or other value-added clinical
1327 programs administered by the managed care plans, but not to exclude
1328 utilization management, claims, member services or other nonclinical
1329 functions.

1330 Sec. 26. (NEW) (*Effective July 1, 2008*) To the extent permitted by
1331 federal law, any employer in the state that offers health care benefits to
1332 its employees shall offer benefits or premium contributions that are
1333 equivalent in value to all such employees regardless of any differential
1334 in the amount of compensation paid to such employees. Nothing in
1335 this section shall preclude an employer from offering employees with a
1336 lower amount of compensation a more comprehensive health care
1337 benefit plan or a higher level of employer premium contribution than
1338 offered to employees receiving a higher amount of compensation.

1339 Sec. 27. (NEW) (*Effective January 1, 2010, and applicable to income years*
1340 *commencing on or after January 1, 2010*) (a) For purposes of this section:

1341 (1) "Employer" means any person, firm, business, educational
1342 institution, nonprofit agency, corporation, limited liability company or
1343 any other business entity which, on at least fifty per cent of its working
1344 days during the preceding twelve months, (A) employed ten or fewer
1345 employees, (B) employed eleven to fifty employees, of whom at least
1346 thirty per cent were paid annualized wages by the employer equal to
1347 or less than three hundred per cent of the federal poverty level for a
1348 family of three, or (C) employed more than fifty employees, at least
1349 seventy-five per cent of whom were paid annualized wages by the
1350 employer equal to or less than one hundred eighty-five per cent of the
1351 federal poverty level for a family of three;

1352 (2) "Full-time employee" means any person employed in or residing
1353 in this state, who is not a temporary or seasonal employee, employed
1354 by an employer and required to work a minimum of thirty-five hours
1355 per week; and

1356 (3) "Part-time employee" means any person employed in or residing
1357 in this state, who is not a temporary or seasonal employee, employed
1358 by an employer and required to work less than thirty-five hours per
1359 week.

1360 (b) (1) There is established a tax credit program to assist employers
1361 with providing health insurance to their employees to achieve the goal
1362 of ensuring greater access to health insurance for residents of this state.
1363 Any employer that elects to claim a tax credit pursuant to this section
1364 shall submit to the Connecticut Connector, as established in section 3
1365 of this act, a copy of such employer's health insurance plan,
1366 documentation of employees' wages and proof of such employer's
1367 premium contributions. If the Connecticut Connector certifies that
1368 such plan meets or exceeds the type and level of benefits of the
1369 Affordable Health Care Plans established pursuant to section 2 of this
1370 act, the Connecticut Connector shall issue a certificate indicating such
1371 fact.

1372 (2) To qualify for a tax credit pursuant to this section, an employer

1373 shall (A) obtain a certificate from the Connecticut Connector in
1374 accordance with this section, and (B) pay a minimum of seventy per
1375 cent of the cost of an employee's health care benefits or a minimum of
1376 fifty per cent of the cost of an employee plus dependents' health care
1377 benefits for full-time employees.

1378 (c) An employer shall be allowed a tax credit against the tax
1379 imposed under chapter 208 of the general statutes for income years
1380 commencing on or after January 1, 2010, in the following amounts:

1381 (1) For employers offering such coverage to all full-time employees
1382 but not part-time employees, the credit shall be in an amount equal to
1383 twenty per cent of the cost of providing health care benefits, provided
1384 such amount shall not exceed eight hundred dollars per employee per
1385 year in the case of a policy covering an individual employee, one
1386 thousand six hundred dollars per employee per year in the case of a
1387 policy covering an employee and only one other individual, or two
1388 thousand four hundred dollars per employee per year in the case of a
1389 policy covering an employee and the family of 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)] P.L. 104-191, as amended
1504 from time to time; and (J) contain additional provisions necessary for

1505 the association to qualify as acceptable coverage in accordance with
1506 the Pension Benefit Guaranty Corporation and Trade Adjustment
1507 Assistance programs of the Trade Act of 2002, [(P.L. 107-210)] P.L. 107-
1508 210, as amended from time to time. The commissioner may adopt
1509 regulations, in accordance with the provisions of chapter 54, to
1510 establish criteria for the association to qualify as an acceptable
1511 alternative mechanism.

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

1539 (11) appoint from among participating members appropriate legal,
1540 actuarial and other committees as necessary to provide technical
1541 assistance in the operation of the association, policy and other contract
1542 design, and any other function within the authority of the association;
1543 and (12) apply for and accept grants, gifts and bequests of funds from
1544 other states, federal and interstate agencies and independent
1545 authorities, private firms, individuals and foundations for the purpose
1546 of carrying out its responsibilities. Any such funds received shall be
1547 deposited in the General Fund and shall be credited to a separate
1548 nonlapsing account within the General Fund for the Health
1549 Reinsurance Association and may be used by the Health Reinsurance
1550 Association in the performance of its duties.

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

1573 of ten lives, provided incurred losses which result from provision of
1574 coverage in accordance with section 38a-537 shall not be considered. In
1575 no event shall the rate for a given classification or group be less than
1576 one hundred twenty-five per cent or more than one hundred fifty per
1577 cent of the average rate charged for that classification with similar
1578 characteristics under a policy covering ten lives. All rates shall be
1579 promulgated by the association through an actuarial committee
1580 consisting of five persons who are members of the American Academy
1581 of Actuaries, shall be filed with the commissioner and may be
1582 disapproved within sixty days from the filing thereof if excessive,
1583 inadequate or unfairly discriminatory.

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

1607 accountant. The annual audit shall be filed with the commissioner for
1608 his review and the association shall be subject to the provisions of
1609 section 38a-14. (4) For the fiscal year ending December 31, 1993, and
1610 the first quarter of the fiscal year ending December 31, 1994, the
1611 administering carrier shall not include health care centers in assessing
1612 any net losses to participating members.

1613 (e) All policy forms issued by or through the association shall
1614 conform in substance to prototype forms developed by the association,
1615 shall in all other respects conform to the requirements of sections 38a-
1616 505, 38a-546 and 38a-551 to 38a-559, inclusive, and shall be approved
1617 by the commissioner. The commissioner may disapprove any such
1618 form if it contains a provision or provisions which are unfair or
1619 deceptive or which encourage misrepresentation of the policy.

1620 (f) Unless otherwise permitted by the plan of operation, the
1621 association shall not issue, reissue or continue in force comprehensive
1622 health care plan coverage with respect to any person who is already
1623 covered under an individual or group comprehensive health care plan,
1624 or who is sixty-five years of age or older and eligible for Medicare or
1625 who is not a resident of this state. Coverage provided to a HIPAA or
1626 health care tax credit eligible individual may be terminated to the
1627 extent permitted by [HIPAA] the Health Insurance Portability and
1628 Accountability Act of 1996, P.L. 104-191, as amended from time to
1629 time, or the Trade Act of 2002, P.L. 107-210, as amended from time to
1630 time, respectively.

1631 (g) Benefits payable under a comprehensive health care plan
1632 insured by or reinsured through the association shall be paid net of all
1633 other health insurance benefits paid or payable through any other
1634 source, and net of all health insurance coverages provided by or
1635 pursuant to any other state or federal law including Title XVIII of the
1636 Social Security Act, Medicare, but excluding Medicaid.

1637 (h) There shall be no liability on the part of and no cause of action of
1638 any nature shall arise against any carrier or its agents or its employees,

1639 the Health Reinsurance Association or its agents or its employees or
1640 the residual market mechanism established under the provisions of
1641 section 38a-557 or its agents or its employees, or the commissioner or
1642 his representatives for any action taken by them in the performance of
1643 their duties under sections 38a-505, 38a-546, [and] 38a-551 to 38a-559,
1644 inclusive, and under sections 3 and 4 of this act. This provision shall
1645 not apply to the obligations of a carrier, a self-insurer, the Health
1646 Reinsurance Association or the residual market mechanism for
1647 payment of benefits provided under a comprehensive health care plan.

1648 Sec. 29. (*Effective July 1, 2008*) Notwithstanding the provisions of
1649 section 4-28e of the general statutes, the sum remaining in the Tobacco
1650 and Health Trust Fund shall be transferred from said fund to the
1651 General Fund, of which twenty million dollars shall be used by the
1652 Department of Public Health for the Connecticut Tobacco Use
1653 Prevention and Control Plan.

1654 Sec. 30. (*Effective July 1, 2008*) The sum of one million dollars is
1655 appropriated to the Department of Public Health, from the General
1656 Fund, for the fiscal year ending June 30, 2009, to expand the
1657 Connecticut Tobacco Use Prevention and Control Plan to cover
1658 smoking cessation medication and supplies, including, but not limited
1659 to, nicotine replacement therapy.

1660 Sec. 31. (*Effective July 1, 2008*) The sum of one million six hundred
1661 thousand dollars is appropriated to the Department of Public Health,
1662 from the General Fund, for the fiscal year ending June 30, 2009, for the
1663 purpose of providing grants to be awarded on July 1, 2009, in the
1664 amount of two hundred thousand dollars to eight different groups
1665 representing the interests of Connecticut employers. The
1666 Commissioner of Public Health, in accordance with the provisions of
1667 chapter 54 of the general statutes, shall establish the criteria and
1668 procedures used to select said groups. Such grants shall be used to
1669 train employers to effectively educate employees concerning the
1670 financial and health benefits of making lifestyle choices that promote
1671 good health, including maintaining a healthy weight and regular

1672 exercise.

1673 Sec. 32. (*Effective July 1, 2008*) The sum of one million dollars is
1674 appropriated to the Department of Social Services, from the General
1675 Fund, for the fiscal year ending June 30, 2009, for the purpose of
1676 obtaining consultant services to assist said department in the
1677 implementation of section 19 of this act.

1678 Sec. 33. (*Effective July 1, 2008*) The sum of ____ dollars is
1679 appropriated to the Office of Health Care Access, from the General
1680 Fund, for the fiscal year ending June 30, 2009, for the purposes of
1681 section 8 of this act.

1682 Sec. 34. (*Effective July 1, 2008*) The sum of ____ dollars is
1683 appropriated to the Office of Health Care Access, from the General
1684 Fund, for the fiscal year ending June 30, 2009, for the purposes of
1685 section 9 of this act.

1686 Sec. 35. (*Effective July 1, 2008*) The sum of five hundred thousand
1687 dollars is appropriated to the Office of Health Care Access, from the
1688 General Fund, for the fiscal year ending June 30, 2009, for the purposes
1689 of the Health Care Reform Commission established under section 2 of
1690 this act.

1691 Sec. 36. (*Effective July 1, 2008*) The sum of five hundred thousand
1692 dollars is appropriated to the Office of Health Care Access, from the
1693 General Fund, for the fiscal year ending June 30, 2009, for the purpose
1694 of providing one-time start-up funds for the establishment of the
1695 Connecticut Health Quality Partnership pursuant to section 14 of this
1696 act, which shall be contingent upon the partnership obtaining a
1697 commitment by six or more members to contribute dues sufficient to
1698 assure the financial viability of the organization.

1699 Sec. 37. (*Effective July 1, 2008*) The sum of two hundred thousand
1700 dollars is appropriated to the Office of Health Care Access, from the
1701 General Fund, for the fiscal year ending June 30, 2009, for the purpose
1702 of conducting the study and survey as required by section 15 of this

1703 act.

1704 Sec. 38. (*Effective July 1, 2008*) The sum of two hundred fifty
1705 thousand dollars is appropriated to the Office of Health Care Access,
1706 from the General Fund, for the fiscal year ending June 30, 2009, for the
1707 purposes of the subcommittee on healthy lifestyles established under
1708 section 13 of this act.

1709 Sec. 39. (*Effective July 1, 2009*) The sum of two hundred sixty
1710 thousand dollars is appropriated to the Office of Health Care Access,
1711 from the General Fund, for the fiscal year ending June 30, 2010, for the
1712 purposes of the subcommittee on healthy lifestyles established under
1713 section 13 of this act.

1714 Sec. 40. (*Effective July 1, 2008*) The sum of one million dollars is
1715 appropriated to the Insurance Department, from the General Fund, for
1716 the fiscal year ending June 30, 2009, for the purpose of providing start-
1717 up costs for the Connecticut Connector including, but not limited to,
1718 web site development, a premium subsidy administration system,
1719 marketing, communications, administrative functions, and purchase of
1720 other technology and equipment to facilitate and streamline operation
1721 and administration of the Connecticut Connector.

1722 Sec. 41. (*Effective July 1, 2008*) (a) The sum of one million five
1723 hundred thousand dollars is appropriated to the Insurance
1724 Department, from the General Fund, for the fiscal year ending June 30,
1725 2009, to operate and administer the Connecticut Connector, and to
1726 market the affordable health care plans.

1727 (b) The sum of one million dollars is appropriated to the Insurance
1728 Department, from the General Fund, for the fiscal year ending June 30,
1729 2010, to operate and administer the Connecticut Connector, and to
1730 market the affordable health care plans.

1731 Sec. 42. (*Effective January 1, 2009*) Section 17b-261c of the general
1732 statutes is repealed.

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	<i>July 1, 2008</i>	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	<i>July 1, 2008</i>	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	<i>July 1, 2008</i>	New section
Sec. 35	<i>July 1, 2008</i>	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, 2009</i>	New section
Sec. 40	<i>July 1, 2008</i>	New section
Sec. 41	<i>July 1, 2008</i>	New section
Sec. 42	<i>January 1, 2009</i>	Repealer section

Statement of Legislative Commissioners:

Technical changes were made for accuracy and clarity. In section 27, the redundant phrase "employed in or residing in this state" in (c) and (d) was removed.

INS *Joint Favorable Subst.*