



General Assembly

January Session, 2009

Committee Bill No. 5172

LCO No. 3725

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Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT ESTABLISHING THE CONNECTICUT HEALTHY STEPS PROGRAM.

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

1 Section 1. (NEW) (*Effective July 1, 2009*) 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 general statutes, section 17b-261 of the general statutes,
4 section 17b-267 of the general statutes, section 17b-292 of the general
5 statutes, and section 38a-567 of the general statutes, as amended by
6 this act, shall be known as the Connecticut Healthy Steps program.

7 Sec. 2. (NEW) (*Effective July 1, 2009*) (a) There is established a
8 permanent Health Care Reform Commission, which shall be an
9 independent, nonprofit body with the Office of Health Care Access for
10 administrative purposes only. The commission shall consist of the
11 Comptroller, the Commissioners of Social Services, Public Health and
12 Health Care Access and the Insurance Commissioner, or their
13 designees, and nine additional members as follows: (1) Two appointed
14 by the speaker of the House of Representatives, one from a consumer
15 advocacy organization and one who shall be an owner of a
16 Connecticut business with fifty or fewer employees in the state; (2) two

17 appointed by the president pro tempore of the Senate, one from a
18 different consumer advocacy organization and one who shall be an
19 owner, senior manager or human resources director of a Connecticut
20 business with more than fifty employees in the state; (3) one appointed
21 by the majority leader of the House of Representatives upon the
22 recommendation of the president of the Connecticut Medical Society;
23 (4) one appointed by the majority leader of the Senate upon the
24 recommendation of the president and chief executive officer of the
25 Connecticut Hospital Association; (5) one appointed by the minority
26 leader of the House of Representatives upon the recommendation of
27 the president and chief executive officer of the Connecticut Business
28 and Industry Association; (6) one appointed by the minority leader of
29 the Senate upon the recommendation of the president of the
30 Connecticut Association of Health Plans; and (7) one appointed by the
31 Governor, who shall be a senior manager or human resources director
32 of a labor union that offers a Taft-Hartley plan.

33 (b) Notwithstanding the provisions of subsection (c) of section 4-9a
34 of the general statutes, the nine additional appointed members of the
35 commission shall serve for staggered terms. The initial members
36 selected shall serve as follows from the date of appointment: (1) The
37 members appointed by the majority leader of the Senate, the minority
38 leader of the House of Representatives and the minority leader of the
39 Senate shall serve for three years; (2) the consumer advocacy member
40 appointed by the speaker of the House of Representatives, the
41 consumer advocacy member appointed by the president pro tempore
42 of the Senate and the member appointed by the majority leader of the
43 House of Representatives shall serve for two years; and (3) the
44 business member appointed by the speaker of the House of
45 Representatives, the business member appointed by the president pro
46 tempore of the Senate and the member appointed by the Governor
47 shall serve for one year. Following the expiration of such initial terms,
48 each subsequent appointee shall serve for a term of three years. Any
49 vacancy occurring other than by expiration of a term shall be filled by
50 the appointing authority for the unexpired portion of the term of the

51 member replaced. Members may be reappointed to serve consecutive
52 terms. The members shall serve without compensation for their
53 services but shall be reimbursed for their expenses.

54 (c) The commission shall:

55 (1) (A) Notwithstanding section 38a-553 of the general statutes, not
56 later than April 1, 2010, design health benefit plans that shall be known
57 as affordable health care plans that meet the requirements of section 4
58 of this act and that shall be approved by the Insurance Commissioner.
59 Not later than January 1, 2011, the Health Reinsurance Association
60 shall make such plans available for sale, and if any employer
61 purchases such plan for its employees through the Connecticut
62 Connector, as defined in section 3 of this act, or any other plan through
63 the Connecticut Connector for its employees that is at least equivalent
64 to the type and level of benefits of affordable health care plans, such
65 employer shall qualify for a tax credit pursuant to section 27 of this act;
66 and (B) adopt rules for the collection of fees in accordance with
67 subdivision (4) of subsection (d) of section 3 of this act;

68 (2) Not later than October 1, 2011, submit a report to the joint
69 standing committee of the General Assembly having cognizance of
70 matters relating to insurance, in accordance with section 11-4a of the
71 general statutes, that identifies the effect of health insurance mandates
72 under chapter 700c of the general statutes on health care premiums
73 paid by private sector employers;

74 (3) Explore incentive options to encourage individuals to use health
75 insurance responsibly;

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

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

81 (6) Not later than July 1, 2010, establish the Connecticut Health
82 Quality Partnership under section 14 of this act;

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

84 (8) Not later than April 1, 2010, develop a plan for (A) the collection
85 of premium from individuals and employers purchasing coverage
86 through the Connecticut Connector, (B) imposition of penalties for late
87 premium payments, as provided in section 38a-483 of the general
88 statutes, and (C) termination of coverage for nonpayment of premium;
89 and

90 (9) Not later than January 1, 2011, and annually thereafter, make
91 recommendations to the General Assembly concerning the
92 implementation of the Connecticut Healthy Steps program and
93 improvements to the health care system, including cost controls.

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

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

101 Sec. 3. (NEW) (*Effective July 1, 2009*) (a) There is established a
102 program which shall be known as the "Connecticut Connector", to be
103 administered in accordance with the provisions of this section by the
104 Health Reinsurance Association established in section 38a-556 of the
105 general statutes, as amended by this act, and through which eligible
106 individuals and employers may purchase affordable health care plans.

107 (b) The Health Reinsurance Association shall administer the
108 Connecticut Connector in accordance with the provisions of section
109 38a-556 of the general statutes, as amended by this act.

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

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

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

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

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

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

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

143 (6) Market the health plans available through the Connecticut
144 Connector to potential purchasers of the health plans including, but
145 not limited to, through the use of advertising, public information
146 campaigns and outreach through the Medicaid and other publicly
147 funded health programs, the chambers of commerce or other trade or
148 professional associations or health care providers;

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

152 (8) Determine employer eligibility for a tax credit and the amount of
153 such tax credit in accordance with section 27 of this act and provide
154 certification for use in claiming such tax credit from the Department of
155 Revenue Services;

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

159 (10) Not later than July 1, 2011, and annually thereafter, provide
160 data and reports to the commission and the General Assembly that
161 shall include, but not be limited to, (A) the number and demographics
162 of previously uninsured persons covered through the Connecticut
163 Connector by type of policy, (B) the per capita administrative costs of
164 the Connecticut Connector, (C) any recommendations for improving
165 service, health insurance policy offerings and costs, and (D) any other
166 information as required by the commission;

167 (11) For individual insurance: (A) Assisted by the commission,
168 notify insurers of the opportunity to make affordable health care plans
169 available for sale through the Connecticut Connector; (B) assisted by

170 the commission, process applications submitted for individual
171 insurance; (C) publish easy to understand materials for prospective
172 purchasers, comparing the costs and benefits of all plans to assist in
173 plan selection; (D) assist applicants to understand the benefits offered
174 under the plans and assist in selecting a plan that reflects the need and
175 income of the applicant, except that such assistance shall not be
176 deemed to require an insurance agent license; (E) work with the
177 insurers selling products through the Connecticut Connector to
178 develop and adopt a uniform tool approved by the Insurance
179 Commissioner for collecting necessary applicant or enrollee data for
180 any appropriate underwriting, enrollment and other purposes; (F)
181 collect premium contributions from employers and individuals, as well
182 as subsidies from the state, and remit them to enrollees' health plans;
183 (G) notify insureds when their premiums are late and disenroll them
184 or levy late penalties in accordance with the provisions of section 38a-
185 483 of the general statutes; and (H) provide information regarding
186 Health Reinsurance Association benefits to applicants who are denied
187 coverage due to underwriting concerns;

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

202 Sec. 4. (NEW) (*Effective January 1, 2011*) (a) The Health Reinsurance

203 Association established pursuant to section 38a-556 of the general
204 statutes, as amended by this act, that administers the Connecticut
205 Connector, as defined in section 3 of this act, shall make available
206 affordable health care plans for individuals and employers established
207 in accordance with standards set forth by the commission.

208 (b) Such plans shall include minimum benefits as follows: (1)
209 Coverage of physician, clinic, ambulatory surgery, laboratory and
210 diagnostic service, in-patient and out-patient hospital care and
211 prescription drugs that are medically necessary, as defined in
212 subsection (a) of section 38a-482a of the general statutes, for physical
213 or mental health; (2) a cap on out-of-pocket costs including, but not
214 limited to, copayments, deductibles and coinsurance that shall reflect
215 the following family income brackets: (A) Family income that is less
216 than two hundred per cent of the federal poverty level, (B) family
217 income that is equal to or greater than two hundred per cent but less
218 than three hundred per cent of the federal poverty level, (C) family
219 income that is greater than three hundred per cent but less than four
220 hundred per cent of the federal poverty level, and (D) family income
221 that is greater than four hundred per cent of the federal poverty level;
222 (3) no deductible for well-child visits, prenatal care and the first two
223 physician visits annually; and (4) a lifetime benefits maximum in an
224 amount not less than five hundred thousand dollars, contingent upon
225 availability of an excess cost reinsurance program established by the
226 Department of Social Services as provided in section 18 of this act. In
227 the event such excess cost reinsurance program is not available, the
228 lifetime benefits maximum shall be in an amount not less than one
229 million dollars.

230 (c) The affordable health care plans shall be exempt from the
231 minimum coverages or benefits set forth in chapter 700c of the general
232 statutes. The premium for such plans shall not exceed two hundred
233 dollars per eligible enrollee or dependent per month on average,
234 adjusted for inflation in average health insurance premiums in the
235 state as determined annually by the Insurance Department. If the

236 Health Reinsurance Association cannot structure an employer plan for
237 this amount or if no carriers are willing to sell a plan for this amount,
238 the commission shall adjust the benefit design.

239 (d) Individual plans offered for sale through the Connecticut
240 Connector shall be specifically priced to reflect the reduced
241 administrative costs to the insurer resulting from the performance of
242 administrative duties by the Connecticut Connector.

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

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

268 condition from coverage.

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

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

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

282 (j) Any employer that purchases an affordable health care plan
283 through the Connecticut Connector may offer its employees only that
284 plan or may offer such plan as a choice among an array of
285 comprehensive plans or a high deductible health plan issued with a
286 health savings account. In the event an employer offers plans in
287 addition to the affordable health care plan, such employer may offer
288 the same percentage or dollar contribution for all plans if such
289 employer allows its employees to select a plan.

290 Sec. 5. (NEW) (*Effective January 1, 2011*) (a) An application by an
291 individual, who can show proof of residency in the state, to purchase
292 coverage through the Connecticut Connector, as defined in section 3 of
293 this act, may be approved in cases in which such individual has no
294 access to employer-sponsored coverage under which the employer
295 pays a minimum of fifty per cent of the cost of such coverage for an
296 individual and his or her dependents and such individual has been
297 either: (1) Uninsured for a period of at least six months; or (2)
298 uninsured for a period of less than six months due to the occurrence of

299 a major life event that has resulted in such uninsured status, including,
300 but not limited to, (A) loss of coverage through the employer, due to
301 termination of employment, (B) death of, or abandonment by, a family
302 member through whom coverage was previously provided, (C) loss of
303 dependent coverage when the individual's spouse became Medicare
304 eligible due to age or disability, (D) loss of coverage as a dependent
305 under any group health insurance policy providing coverage of the
306 type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section
307 38a-469 of the general statutes due to age, divorce or other changes in
308 status, (E) expiration of the coverage periods established by the
309 Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272,
310 as amended from time to time, (F) extreme economic hardship on the
311 part of either the employee or the employer, as determined by the
312 organization that administers the Connecticut Connector, in
313 accordance with specific measurable criteria defined by the
314 commission, and (G) any other events that may be specified by the
315 commission. For purposes of this subsection, "proof of residency"
316 means evidence of domicile in the state such as voter registration, tax
317 filings, utility bill or other documentation deemed satisfactory by the
318 Insurance Commissioner.

319 (b) An application by an employer to purchase coverage through
320 the Connecticut Connector may be approved if such employer: (1) Has
321 fifty or fewer employees; (2) has not offered a comprehensive health
322 insurance plan to any employee for a period of at least six months; (3)
323 will contribute a minimum of seventy per cent of the cost of the
324 affordable health care plan for an employee or a minimum of fifty per
325 cent of the cost of an employee plus dependent coverage under the
326 least expensive plan available through the Connecticut Connector for
327 any dependent of such employee; and (4) attests to the Health
328 Reinsurance Association that at least ninety per cent of the employer's
329 employees either have coverage through another health care plan or
330 will enroll in a health care plan through the Connecticut Connector.

331 Sec. 6. (NEW) (*Effective January 1, 2011*) (a) (1) As used in this

332 section:

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

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

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

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

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

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

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

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

351 (2) There is established a nonprofit entity which shall be known as
352 the "Connecticut Individual Health Reinsurance Pool". All insurers
353 delivering, issuing for delivery, renewing, amending or continuing
354 health insurance in this state on and after January 1, 2011, shall be
355 members of the pool. The board of directors of the Connecticut Small
356 Employer Health Reinsurance Pool established under section 38a-569
357 of the general statutes shall administer the pool.

358 (3) Not later than ninety days after January 1, 2011, the board shall
359 submit to the commissioner a plan of operation and, thereafter, any

360 amendments thereto necessary or suitable to assure the fair, reasonable
361 and equitable administration of the pool. The commissioner shall, after
362 notice and hearing, approve the plan of operation, provided the
363 commissioner determines it to be suitable to assure the fair, reasonable
364 and equitable administration of the pool, and provides for the sharing
365 of pool gains or losses on an equitable proportionate basis in
366 accordance with the provisions of subsection (d) of this section. The
367 plan of operation shall become effective upon approval, in writing, by
368 the commissioner consistent with the date on which the coverage
369 under this section shall be made available. If the board fails to submit a
370 suitable plan of operation not later than one hundred eighty days after
371 January 1, 2011, or at any time thereafter fails to submit suitable
372 amendments to the plan of operation, the commissioner shall, after
373 notice and hearing, adopt and promulgate a plan of operation or
374 amendments, as appropriate. The commissioner shall amend any plan
375 adopted, as necessary, at the time a plan of operation is submitted by
376 the board and approved by the commissioner.

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

386 (5) The pool shall have the general powers and authority granted
387 under the laws of Connecticut to insurance companies licensed to
388 transact health insurance and, in addition thereto, the specific
389 authority to: (A) Enter into contracts as are necessary or proper to
390 carry out the provisions and purposes of this section, including the
391 authority, with the approval of the commissioner, to enter into
392 contracts with programs of other states for the joint performance of

393 common functions, or with persons or other organizations for the
394 performance of administrative functions; (B) sue or be sued, including
395 taking any legal actions necessary or proper for recovery of any
396 assessments for, on behalf of or against members; (C) take such legal
397 action as necessary to avoid the payment of improper claims against
398 the pool; (D) define the array of health coverage products for which
399 reinsurance will be provided, and to issue reinsurance policies, in
400 accordance with the requirements of this section; (E) establish rules,
401 conditions and procedures pertaining to the reinsurance of members'
402 risks by the pool; (F) establish appropriate rates, rate schedules, rate
403 adjustments, rate classifications and any other actuarial functions
404 appropriate to the operation of the pool; (G) assess members in
405 accordance with the provisions of subsection (e) of this section, and to
406 make advance interim assessments as may be reasonable and
407 necessary for organizational and interim operating expenses. Any such
408 interim assessments shall be credited as offsets against any regular
409 assessments due following the close of the fiscal year; (H) appoint from
410 among members appropriate legal, actuarial and other committees as
411 necessary to provide technical assistance in the operation of the pool,
412 policy and other contract design, and any other function within the
413 authority of the pool; and (I) borrow money to effect the purposes of
414 the pool. Any notes or other evidence of indebtedness of the pool not
415 in default shall be legal investments for insurers and may be carried as
416 admitted assets.

417 (b) Any member may reinsure with the pool coverage of an eligible
418 individual, as defined in the pool's plan of operation, who has an
419 identified preexisting condition. The pool reimbursement relative to
420 such preexisting condition shall be limited to the actual paid reinsured
421 benefits in excess of five thousand dollars but not greater than seventy-
422 five thousand dollars for the first twelve months of the term of the
423 individual affordable health care plan reinsured pursuant to this
424 subsection. The board of directors of said pool shall determine the
425 reinsurance premium rated in accordance with the provisions of
426 section 38a-570 of the general statutes. Such amounts shall be annually

427 indexed to the consumer price index for medical care. Any reinsurance
428 placed with the pool from the date of the establishment of the pool
429 regarding such coverage shall be approved by the commissioner. The
430 commissioner may adopt regulations, in accordance with chapter 54 of
431 the general statutes, to implement the requirements of this section.

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

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

441 (e) Subject to subsection (c) of this section, (1) following the close of
442 each fiscal year, the administrator shall determine the net premiums,
443 the pool expenses of administration and the incurred losses for the
444 year, taking into account investment income and other appropriate
445 gains and losses. Health insurance premiums and benefits paid by a
446 member that are less than an amount determined by the board to
447 justify the cost of collection shall not be considered for purposes of
448 determining assessments. For purposes of this subsection, "net
449 premiums" means health insurance premiums, less administrative
450 expense allowances.

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

453 (A) Assessments shall first be apportioned by the board of directors
454 of such reinsurance pool among all members in proportion to their
455 respective shares of the total health insurance premiums earned in this
456 state from health insurance plans covering individuals during the
457 calendar year coinciding with or ending during the fiscal year of the

458 pool, or on any other equitable basis reflecting coverage of individuals
459 as may be provided in the plan of operations. An assessment shall be
460 made pursuant to this subparagraph against a health care center
461 approved by the Secretary of Health and Human Services as a health
462 maintenance organization pursuant to 42 USC 300e et seq., subject to
463 an assessment adjustment formula adopted by the board and
464 approved by the commissioner for such health care centers, that
465 recognizes the restrictions imposed on such health care centers by
466 federal law. Such adjustment formula shall be adopted by the board
467 and approved by the commissioner prior to the first anniversary of the
468 pool's operation.

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

477 (C) Notwithstanding the provisions of this subdivision, the
478 assessments to any one member under subparagraph (A) or (B) of this
479 subdivision shall not exceed forty per cent of the total assessment
480 under each subparagraph for the first fiscal year of the pool's operation
481 and fifty per cent of the total assessment under each subparagraph for
482 the second fiscal year. Any amounts abated pursuant to this
483 subparagraph shall be assessed against the other members in a manner
484 consistent with the basis for assessments set forth in this subdivision.

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

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

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

496 (6) The said board of directors may defer, in whole or in part, the
497 assessment of a health care center if, in the opinion of the board: (A)
498 Payment of the assessment would endanger the ability of the health
499 care center to fulfill its contractual obligations, or (B) in accordance
500 with standards included in the plan of operation, the health care center
501 has written, and reinsured in their entirety, a disproportionate number
502 of individual health care plans offered under section 4 of this act. In
503 the event an assessment against a health care center is deferred in
504 whole or in part, the amount by which such assessment is deferred
505 may be assessed against the other members in a manner consistent
506 with the basis for assessments set forth in this subsection. The health
507 care center receiving such deferment shall remain liable to the pool for
508 the amount deferred. The board may attach appropriate conditions to
509 any such deferment.

510 (f) (1) Neither the participation in the pool as members, the
511 establishment of rates, forms or procedures nor any other joint or
512 collective action required by this section shall be the basis of any legal
513 action, criminal or civil liability or penalty against the pool or any of its
514 members.

515 (2) Any person or member made a party to any action, suit or
516 proceeding because the person or member served on the board of
517 directors of such reinsurance pool or on a committee or was an officer
518 or employee of the pool shall be held harmless and be indemnified
519 against all liability and costs, including the amounts of judgments,
520 settlements, fines or penalties, and expenses and reasonable attorney's
521 fees incurred in connection with the action, suit or proceeding. The

522 indemnification shall not be provided on any matter in which the
523 person or member is finally adjudged in the action, suit or proceeding
524 to have committed a breach of duty involving gross negligence,
525 dishonesty, wilful misfeasance or reckless disregard of the
526 responsibilities of office. Costs and expenses of the indemnification
527 shall be prorated and paid for by all members. The commissioner may
528 retain actuarial consultants necessary to carry out his or her
529 responsibilities pursuant to this section, and such expenses shall be
530 paid by the pool established in this section.

531 Sec. 7. (NEW) (*Effective October 1, 2009*) (a) The Health Reinsurance
532 Association, on behalf of the Connecticut Connector, as defined in
533 section 3 of this act, shall, not later than thirty days after receipt of all
534 relevant information provided by an employer, determine whether to
535 certify that an employer is eligible for a tax credit pursuant to section
536 27 of this act.

537 (b) The Health Reinsurance Association shall provide information to
538 employers seeking assistance with obtaining certification pursuant to
539 this section.

540 Sec. 8. (NEW) (*Effective October 1, 2010*) (a) There is established the
541 health savings account incentive program. To be eligible for payment
542 pursuant to this section, an individual's family income shall not exceed
543 three hundred per cent of the federal poverty level. The Health
544 Reinsurance Association, on behalf of the Connecticut Connector, as
545 defined in section 3 of this act, shall annually contribute to the health
546 savings account of any individual who has resided in the state for a
547 period of not less than six months and who has a health savings
548 account and high deductible health plan pursuant to Section 223 of the
549 Internal Revenue Code of 1986, or any subsequent corresponding
550 internal revenue code of the United States, as amended from time to
551 time, an amount determined by a sliding scale as follows:

552 (1) For a family income equal to or less than two hundred per cent
553 of the federal poverty level: Five hundred dollars for an individual

554 who has contributed or received contributions of at least two thousand
555 five hundred dollars in his or her health savings account in the
556 previous year; one thousand dollars for a family of two who has
557 contributed or received contributions of at least three thousand seven
558 hundred fifty dollars in their health savings account in the previous
559 year; or one thousand five hundred dollars for a family of three or
560 more who has contributed or received contributions of at least five
561 thousand dollars in their health savings account in the previous year;

562 (2) For a family income greater than two hundred per cent but less
563 than three hundred per cent of the federal poverty level: Four hundred
564 dollars for an individual who has contributed or received
565 contributions of at least two thousand five hundred dollars in his or
566 her health savings account in the previous year; eight hundred dollars
567 for a family of two who has contributed or received contributions of at
568 least three thousand seven hundred fifty dollars in their health savings
569 account in the previous year; or one thousand two hundred dollars for
570 a family of three or more who has contributed or received
571 contributions of at least five thousand dollars in their health savings
572 account in the previous year.

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

576 (c) Notwithstanding the provisions of subsection (a) of this section,
577 the Health Reinsurance Association shall not make contributions on
578 behalf of the Connecticut Connector to the health savings account of
579 any individual if the total amount in such account exceeds the
580 deductible amount in the high deductible health plan.

581 (d) The Health Reinsurance Association shall make payments on
582 behalf of the Connecticut Connector, in accordance with the provisions
583 of this section, by January thirtieth of any year for health savings
584 account contributions in the prior calendar year. The Health
585 Reinsurance Association shall establish procedures by which

586 individuals may claim payment pursuant to this section.

587 Sec. 9. (NEW) (*Effective October 1, 2010*) (a) There is established the
588 health insurance premium subsidy program. To be eligible for
589 payment pursuant to this section, an individual (1) shall not have
590 family income greater than three hundred per cent of the federal
591 poverty level, (2) shall not individually or as part of a family own a
592 health savings account pursuant to Section 223 of the Internal Revenue
593 Code of 1986, or any subsequent corresponding internal revenue code
594 of the United States, as amended from time to time, and (3) shall have
595 an affordable health care plan purchased through the Connecticut
596 Connector, as defined in section 3 of this act, or any group health
597 insurance policy providing coverage of the type specified in
598 subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 of the
599 general statutes for which the employee pays at least five hundred
600 dollars in premiums annually to the employee's employer if single and
601 at least one thousand dollars in premiums annually to the employee's
602 employer if the employee is covered by a family plan or under a
603 nonemployer-based plan purchased through the individual market or
604 the Connecticut Connector. The Health Reinsurance Association, on
605 behalf of the Connecticut Connector, shall quarterly reimburse an
606 individual who is eligible pursuant to this section for premiums paid
607 in the preceding quarter an average amount as follows:

608 (A) For a family with income equal to or less than two hundred per
609 cent of the federal poverty level: Eighty per cent of the individual
610 premium or of their share of the premium for an employer-sponsored
611 plan, not to exceed three hundred dollars per quarter for an individual,
612 six hundred dollars per quarter for an individual plus one dependent
613 or nine hundred dollars per quarter for a family;

614 (B) For a family with income greater than two hundred per cent but
615 less than three hundred per cent of the federal poverty level: Sixty per
616 cent of the individual premium or of their share of the premium for an
617 employer-sponsored plan, not to exceed one hundred fifty dollars per

618 quarter for an individual, three hundred dollars per quarter for an
619 individual plus one dependent or four hundred fifty dollars per
620 quarter for a family.

621 (b) The dollar amounts specified in subparagraphs (A) and (B) of
622 subdivision (3) of subsection (a) of this section shall be adjusted in the
623 case of an individual seeking payment for the purchase of an
624 individual insurance plan based on the age, gender and county of
625 residence of the individual and calculated by the Connecticut
626 Connector to reflect the differences in premiums applied to each rating
627 classification.

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

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

634 Sec. 10. Section 38a-567 of the general statutes is repealed and the
635 following is substituted in lieu thereof (*Effective January 1, 2010*):

636 Health insurance plans and insurance arrangements covering small
637 employers and insurers and producers marketing such plans and
638 arrangements shall be subject to the following provisions:

639 (1) (A) Any such plan or arrangement shall be renewable with
640 respect to all eligible employees or dependents at the option of the
641 small employer, policyholder or contractholder, as the case may be,
642 except: (i) For nonpayment of the required premiums by the small
643 employer, policyholder or contractholder; (ii) for fraud or
644 misrepresentation of the small employer, policyholder or
645 contractholder or, with respect to coverage of individual insured, the
646 insureds or their representatives; (iii) for noncompliance with plan or
647 arrangement provisions; (iv) when the number of insureds covered

648 under the plan or arrangement is less than the number of insureds or
649 percentage of insureds required by participation requirements under
650 the plan or arrangement; or (v) when the small employer, policyholder
651 or contractholder is no longer actively engaged in the business in
652 which it was engaged on the effective date of the plan or arrangement.

653 (B) Renewability of coverage may be effected by either continuing in
654 effect a plan or arrangement covering a small employer or by
655 substituting upon renewal for the prior plan or arrangement the plan
656 or arrangement then offered by the carrier that most closely
657 corresponds to the prior plan or arrangement and is available to other
658 small employers. Such substitution shall only be made under
659 conditions approved by the commissioner. A carrier may substitute a
660 plan or arrangement as stated above only if the carrier effects the same
661 substitution upon renewal for all small employers previously covered
662 under the particular plan or arrangement, unless otherwise approved
663 by the commissioner. The substitute plan or arrangement shall be
664 subject to the rating restrictions specified in this section on the same
665 basis as if no substitution had occurred, except for an adjustment
666 based on coverage differences.

667 (C) Notwithstanding the provisions of this subdivision, any such
668 plan or arrangement, or any coverage provided under such plan or
669 arrangement may be rescinded for fraud, material misrepresentation
670 or concealment by an applicant, employee, dependent or small
671 employer.

672 (D) Any individual who was not a late enrollee at the time of his or
673 her enrollment and whose coverage is subsequently rescinded shall be
674 allowed to reenroll as of a current date in such plan or arrangement
675 subject to any preexisting condition or other provisions applicable to
676 new enrollees without previous coverage. On and after the effective
677 date of such individual's reenrollment, the small employer carrier may
678 modify the premium rates charged to the small employer for the
679 balance of the current rating period and for future rating periods, to

680 the level determined by the carrier as applicable under the carrier's
681 established rating practices had full, accurate and timely underwriting
682 information been supplied when such individual initially enrolled in
683 the plan. The increase in premium rates allowed by this provision for
684 the balance of the current rating period shall not exceed twenty-five
685 per cent of the small employer's current premium rates. Any such
686 increase for the balance of said current rating period shall not be
687 subject to the rate limitation specified in subdivision (6) of this section.
688 The rate limitation specified in this section shall otherwise be fully
689 applicable for the current and future rating periods. The modification
690 of premium rates allowed by this subdivision shall cease to be
691 permitted for all plans and arrangements on the first rating period
692 commencing on or after July 1, 1995.

693 (2) Except in the case of a late enrollee who has failed to provide
694 evidence of insurability satisfactory to the insurer, the plan or
695 arrangement may not exclude any eligible employee or dependent
696 who would otherwise be covered under such plan or arrangement on
697 the basis of an actual or expected health condition of such person. No
698 plan or arrangement may exclude an eligible employee or eligible
699 dependent who, on the day prior to the initial effective date of the plan
700 or arrangement, was covered under the small employer's prior health
701 insurance plan or arrangement pursuant to workers' compensation,
702 continuation of benefits pursuant to federal extension requirements
703 established by the Consolidated Omnibus Budget Reconciliation Act of
704 1985 (P.L. 99-2721, as amended) or other applicable laws. The
705 employee or dependent must request coverage under the new plan or
706 arrangement on a timely basis and such coverage shall terminate in
707 accordance with the provisions of the applicable law.

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

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

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

723 (A) The percentage change in the base premium rate measured from
724 the first day of the prior rating period to the first day of the new rating
725 period;

726 (B) An adjustment of the small employer's premium rates for the
727 prior rating period, and adjusted pro rata for rating periods of less
728 than one year, due to the claim experience, health status or duration of
729 coverage of the employees or dependents of the small employer, such
730 adjustment (i) not to exceed ten per cent annually for the rating
731 periods commencing on or after October 1, 1993, and prior to July 1,
732 1994, and (ii) not to exceed five per cent annually for the rating periods
733 commencing on or after July 1, 1994, and prior to July 1, 1995; and

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

737 (5) (A) With respect to plans or arrangements delivered, issued for
738 delivery, renewed, amended or continued on or after [July 1, 1995,]
739 January 1, 2010, the premium rates charged or offered to small
740 employers shall be established on the basis of a community rate,
741 adjusted to reflect one or more of the following classifications:

742 (i) Age, provided age brackets of less than five years shall not be

743 utilized;

744 (ii) Gender;

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

747 (iv) Industry, provided the rate factor associated with any industry
748 classification shall not vary from the arithmetic average of the highest
749 and lowest rate factors associated with all industry classifications by
750 greater than fifteen per cent of such average, and provided further, the
751 rate factors associated with any industry shall not be increased by
752 more than five per cent per year;

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

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

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

768 (viii) Family composition, provided the small employer carrier shall
769 utilize only one or more of the following billing classifications: (I)
770 Employee; (II) employee plus family; (III) employee and spouse; (IV)
771 employee and child; (V) employee plus one dependent; and (VI)
772 employee plus two or more dependents; and

773 (ix) Participation in a smoking cessation program that complies with
774 the Health Insurance Portability and Accountability Act of 1996, P.L.
775 104-191, as amended from time to time.

776 (B) The small employer carrier shall quote premium rates to small
777 employers after receipt of all demographic rating classifications of the
778 small employer group. No small employer carrier may inquire
779 regarding health status or claims experience of the small employer or
780 its employees or dependents prior to the quoting of a premium rate.

781 (C) The provisions of subparagraphs (A) and (B) of this subdivision
782 shall apply to plans or arrangements issued on or after July 1, 1995.
783 The provisions of subparagraphs (A) and (B) of this subdivision shall
784 apply to plans or arrangements issued prior to July 1, 1995, as of the
785 date of the first rating period commencing on or after that date, but no
786 later than July 1, 1996.

787 (6) For any small employer plan or arrangement on which the
788 premium rates for employee and dependent coverage or both, vary
789 among employees, such variations shall be based solely on age and
790 other demographic factors permitted under subparagraph (A) of
791 subdivision (5) of this section and such variations may not be based on
792 health status, claim experience, or duration of coverage of specific
793 enrollees. Except as otherwise provided in subdivision (1) of this
794 section, any adjustment in premium rates charged for a small
795 employer plan or arrangement to reflect changes in case characteristics
796 prior to the end of a rating period shall not include any adjustment to
797 reflect the health status, medical history or medical underwriting
798 classification of any new enrollee for whom coverage begins during
799 the rating period.

800 (7) For rating periods commencing prior to July 1, 1995, in any case
801 where a small employer carrier utilized industry classification as a case
802 characteristic in establishing premium rates, the rate factor associated
803 with any industry classification shall not vary from the arithmetical
804 average of the highest and lowest rate factors associated with all

805 industry classifications by greater than fifteen per cent of such average.

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

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

819 (10) If a small employer carrier denies coverage as requested to a
820 small employer that is self-employed, the small employer carrier shall
821 promptly offer such small employer the opportunity to purchase a
822 small employer health care plan. If a small employer carrier or any
823 producer representing that carrier fails, for any reason, to offer
824 coverage as requested by a small employer that is self-employed, that
825 small employer carrier shall promptly offer such small employer an
826 opportunity to purchase a small employer health care plan.

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

829 (A) Encouraging or directing small employers to refrain from filing
830 an application for coverage with the small employer carrier because of
831 the health status, claims experience, industry, occupation or
832 geographic location of the small employer, except the provisions of
833 this subparagraph shall not apply to information provided by a small
834 employer carrier or producer to a small employer regarding the
835 carrier's established geographic service area or a restricted network

836 provision of a small employer carrier; or

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

840 (12) No small employer carrier shall, directly or indirectly, enter into
841 any contract, agreement or arrangement with a producer that provides
842 for or results in the compensation paid to a producer for the sale of a
843 health benefit plan to be varied because of the health status, claims
844 experience, industry, occupation or geographic area of the small
845 employer. A small employer carrier shall provide reasonable
846 compensation, as provided under the plan of operation of the
847 program, to a producer, if any, for the sale of a special or a small
848 employer health care plan. No small employer carrier shall terminate,
849 fail to renew or limit its contract or agreement of representation with a
850 producer for any reason related to the health status, claims experience,
851 occupation, or geographic location of the small employers placed by
852 the producer with the small employer carrier.

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

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

860 (15) No small employer carrier or producer shall disclose (A) to a
861 small employer the fact that any or all of the eligible employees of such
862 small employer have been or will be reinsured with the pool, or (B) to
863 any eligible employee or dependent the fact that he has been or will be
864 reinsured with the pool.

865 (16) If a small employer carrier enters into a contract, agreement or

866 other arrangement with another party to provide administrative,
867 marketing or other services related to the offering of health benefit
868 plans to small employers in this state, the other party shall be subject
869 to the provisions of this section.

870 (17) The commissioner may adopt regulations, in accordance with
871 the provisions of chapter 54, setting forth additional standards to
872 provide for the fair marketing and broad availability of health benefit
873 plans to small employers.

874 (18) Each small employer carrier shall maintain at its principal place
875 of business a complete and detailed description of its rating practices
876 and renewal underwriting practices, including information and
877 documentation that demonstrates that its rating methods and practices
878 are based upon commonly accepted actuarial assumptions and are in
879 accordance with sound actuarial principles. Each small employer
880 carrier shall file with the commissioner annually, on or before March
881 fifteenth, an actuarial certification certifying that the carrier is in
882 compliance with this part and that the rating methods have been
883 derived using recognized actuarial principles consistent with the
884 provisions of sections 38a-564 to 38a-573, inclusive. Such certification
885 shall be in a form and manner and shall contain such information, as
886 determined by the commissioner. A copy of the certification shall be
887 retained by the small employer carrier at its principle place of business.
888 Any information and documentation described in this subdivision but
889 not subject to the filing requirement shall be made available to the
890 commissioner upon his request. Except in cases of violations of
891 sections 38a-564 to 38a-573, inclusive, as amended by this act, the
892 information shall be considered proprietary and trade secret
893 information and shall not be subject to disclosure by the commissioner
894 to persons outside of the department except as agreed to by the small
895 employer carrier or as ordered by a court of competent jurisdiction.

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

898 employers for one or more rating periods upon a filing by the small
899 employer carrier and a finding by the commissioner that either the
900 suspension is reasonable in light of the financial condition of the
901 carrier or that the suspension would enhance the efficiency and
902 fairness of the marketplace for small employer health insurance.

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

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

911 (22) (A) With respect to plans or arrangements issued pursuant to
912 subsection (i) of section 5-259, at the option of the Comptroller, the
913 premium rates charged or offered to small employers purchasing
914 health insurance shall not be subject to this section, provided (i) the
915 plan or plans offered or issued cover such small employers as a single
916 entity and cover not less than three thousand employees on the date
917 issued, (ii) each small employer is charged or offered the same
918 premium rate with respect to each employee and dependent, and (iii)
919 the plan or plans are written on a guaranteed issue basis.

920 (B) With respect to plans or arrangements issued by an association
921 group plan, at the option of the administrator of the association group
922 plan, the premium rates charged or offered to small employers
923 purchasing health insurance shall not be subject to this section,
924 provided (i) the plan or plans offered or issued cover such small
925 employers as a single entity and cover not less than three thousand
926 employees on the date issued, (ii) each small employer is charged or
927 offered the same premium rate with respect to each employee and
928 dependent, and (iii) the plan or plans are written on a guaranteed issue
929 basis. In addition, such association group (I) shall be a bona fide group

930 as set forth in the Employee Retirement and Security Act of 1974, (II)
931 shall not be formed for the purposes of fictitious grouping, as defined
932 in section 38a-827, and (III) shall not issue any plan that shall cause
933 undue disruption in the insurance marketplace, as determined by the
934 commissioner.

935 Sec. 11. (NEW) (*Effective July 1, 2009*) The Department of Public
936 Health shall establish and offer incentives for physicians in private
937 practice who provide their services for at least four hours to federally
938 qualified health centers, community health centers, community mental
939 health centers or school-based clinics. Such incentives may include, but
940 not be limited to, reduced cost medical malpractice insurance offered
941 or arranged for by the department and loan forgiveness from
942 postsecondary educational institutions that receive funding from the
943 state and partial payment of educational loans.

944 Sec. 12. (NEW) (*Effective July 1, 2009*) Not later than January 1, 2010,
945 the Department of Public Health shall expand the Connecticut Tobacco
946 Use Prevention and Control Plan to offer, within available
947 appropriations, smoking cessation medication and supplies, including,
948 but not limited to, nicotine replacement therapy.

949 Sec. 13. (NEW) (*Effective January 1, 2010*) (a) The Health Care Reform
950 Commission, established under section 2 of this act, shall establish a
951 subcommittee on healthy lifestyles, comprised of six members of said
952 commission, to be selected by the Commissioner of Health Care
953 Access. The subcommittee shall: (1) Not later than March 1, 2011,
954 develop a marketing campaign to educate the public regarding
955 consequences of poor health and basic measures individuals should
956 take to ensure good health; and (2) make recommendations to the
957 General Assembly concerning incentives to encourage personal
958 responsibility in making healthy lifestyle choices.

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

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

966 Sec. 14. (NEW) (*Effective July 1, 2009*) (a) Not later than July 1, 2010,
967 the Health Care Reform Commission, established under section 2 of
968 this act, shall establish the Connecticut Health Quality Partnership.
969 The members of the partnership shall be appointed by the
970 Commissioner of Health Care Access, and shall consist of a minimum
971 of eight representatives from both the private and public sectors,
972 including, but not limited to, health insurers, hospital associations, a
973 representative of physicians, the Commissioners of Public Health and
974 Social Services or their designees, representatives of Medicaid
975 managed care organizations and not more than two consumer
976 advocates who are not otherwise affiliated with any other members.
977 The commission shall assign staff to assist the partnership with its
978 responsibilities.

979 (b) The Connecticut Health Quality Partnership shall: (1) Be
980 responsible for collecting and analyzing insurance and Medicaid
981 claims data and other data concerning the quality of care and services
982 provided by health care providers, for the purpose of supporting
983 quality improvement initiatives and enabling consumers to make
984 informed choices with respect to such health care providers; (2)
985 provide comparative data to health care providers concerning the
986 quality of their performance relative to their peers; (3) be responsible
987 for collecting and analyzing data from hospitals pertaining to
988 nosocomial infections for the purpose of tracking, reporting and
989 reducing nosocomial infection rates; (4) be responsible for collecting
990 and analyzing such data from other health care providers, as it deems
991 necessary; (5) be responsible for annually selecting state-wide quality
992 improvement initiatives and encouraging all health plans to adopt
993 such quality improvement initiatives with the same goals and metrics;
994 (6) seek funding from private and federal funding sources; and (7) seek

995 accreditation not later than July 1, 2014, by the National Committee for
996 Quality Assurance as a Quality Plus program.

997 Sec. 15. (NEW) (*Effective October 1, 2009*) (a) Not later than January 1,
998 2010, and every five years thereafter, the Office of Health Care Access
999 shall determine the number of residents of this state who are not
1000 covered by a health insurance plan. If, by January 1, 2015, the number
1001 of uninsured residents has not decreased by fifty per cent from the
1002 date of the first determination, the Health Care Reform Commission
1003 established by section 2 of this act, shall determine whether it is
1004 advisable to require all or certain residents to have health insurance.
1005 Not later than January 1, 2016, the commission shall report its findings
1006 and recommendations, in accordance with section 11-4a of the general
1007 statutes, to the joint standing committee of the General Assembly
1008 having cognizance of matters relating to insurance.

1009 (b) Not later than December 31, 2010, and annually thereafter, the
1010 Office of Health Care Access shall conduct a survey to determine the
1011 number of employers in the state providing health care benefits to
1012 employees who reside in this state. Not later than January 1, 2011, and
1013 annually thereafter, the office shall submit a report of its findings, in
1014 accordance with section 11-4a of the general statutes, to the joint
1015 standing committee of the General Assembly having cognizance of
1016 matters relating to insurance.

1017 Sec. 16. (*Effective July 1, 2009*) (a) The Commissioner of Public Health
1018 shall identify and evaluate current health care programs that provide
1019 services to residents of this state who are uninsured.

1020 (b) Not later than September 1, 2010, the Commissioner of Public
1021 Health shall submit a report, in accordance with section 11-4a of the
1022 general statutes, of findings and recommendations to the joint
1023 standing committees of the General Assembly having cognizance of
1024 matters relating to public health and appropriations and the budgets of
1025 state agencies. Such report shall identify the programs that are likely to
1026 experience a decrease in utilization due to the implementation of the

1027 programs and plans established under the Connecticut Healthy Steps
1028 program and the amount of such decrease, to the extent feasible.

1029 Sec. 17. (NEW) (*Effective July 1, 2009*) The Office of Health Care
1030 Access shall utilize the data obtained pursuant to section 15 of this act
1031 relative to any decreases in the number of uninsured residents of this
1032 state to make recommendations to the Department of Social Services
1033 for commensurate decreases in the disproportionate share payments to
1034 hospitals in accordance with the provisions of section 19a-671 of the
1035 general statutes.

1036 Sec. 18. (NEW) (*Effective July 1, 2009*) The Commissioner of Social
1037 Services shall establish an excess cost reinsurance program to carry out
1038 the provisions of subparagraph (D) of subdivision (1) of subsection (b)
1039 of section 4 of this act. Such program shall (1) disregard assets equal to
1040 the amount of insurance premium payments paid by an insured for an
1041 affordable health care plan for the two years prior to Medicaid
1042 application, and (2) disregard as income the amount of insurance
1043 premium payments made by an insured for an affordable health care
1044 plan in the year of Medicaid application. Said commissioner may
1045 adopt regulations, in accordance with chapter 54 of the general
1046 statutes, to implement the requirements of this section.

1047 Sec. 19. (NEW) (*Effective July 1, 2009*) Not later than December 31,
1048 2009, the Commissioner of Social Services shall seek a waiver or
1049 waivers of federal Medicaid rules for the purposes of (1) obtaining any
1050 available federal reimbursement, including federal financial
1051 participation, for state expenditures related to the health savings
1052 account incentive program established under section 8 of this act and
1053 the premium subsidy program established under section 9 of this act,
1054 and (2) establishing a state excess cost reinsurance program for
1055 enrollees in the Connecticut Connector's affordable health care plan to
1056 allow such enrollees to obtain coverage through the Medicaid program
1057 once their insurance benefits are exhausted without having to spend
1058 down their assets.

1059 Sec. 20. (NEW) (*Effective July 1, 2009*) (a) The Commissioner of Social
1060 Services shall develop a plan to improve the coordination of the
1061 delivery of health care services to all or a substantial subset of the
1062 aged, blind and disabled Medicaid beneficiaries. Such plan shall
1063 include programs to (1) improve coordination of and access to medical
1064 services, social services and housing, (2) implement chronic disease
1065 management programs, (3) use predictive modeling to identify high
1066 risk, complex and high-cost Medicaid beneficiaries, and (4) provide
1067 such beneficiaries with intensive clinical care coordination and
1068 pharmacological management. The commissioner may contract with
1069 an administrative services organization to effectuate the
1070 implementation of such plan.

1071 (b) Such plan shall also address: (1) Provider reimbursement
1072 systems that are aligned with the goal of managing the care of
1073 individuals who have, or are at risk for having, chronic health
1074 conditions in order to improve health outcomes and the quality of care
1075 for such individuals; and (2) the use and development of outcome
1076 measures and reporting requirements, aligned with existing outcome
1077 measures within the Department of Social Services, to assess and
1078 evaluate the system of chronic care.

1079 (c) Not later than January 1, 2010, the Commissioner of Social
1080 Services shall submit such plan, in accordance with section 11-4a of the
1081 general statutes, to the joint standing committees of the General
1082 Assembly having cognizance of matters relating to human services and
1083 appropriations and the budgets of state agencies. On October 1, 2011,
1084 and annually thereafter, the Commissioner of Social Services shall
1085 report, in accordance with the provisions of section 11-4a of the general
1086 statutes, on the status of implementation of such plan to the joint
1087 standing committees of the General Assembly having cognizance of
1088 matters relating to human services and appropriations and the budgets
1089 of state agencies. The report shall include the number of individuals
1090 and health care providers participating in the programs specified in
1091 subsection (a) of this section, indicators of quality improvement and

1092 patient satisfaction, annual expenditures and savings associated with
1093 the plan and such other information as may be requested by said joint
1094 standing committees.

1095 Sec. 21. (NEW) (*Effective July 1, 2009*) On and after January 1, 2010,
1096 the Commissioner of Social Services shall allow aged, blind or disabled
1097 Medicaid beneficiaries to voluntarily enroll in the managed care plans
1098 available to HUSKY Plan, Part A and HUSKY Plan, Part B
1099 beneficiaries.

1100 Sec. 22. Subsection (a) of section 17b-192 of the general statutes is
1101 repealed and the following is substituted in lieu thereof (*Effective July*
1102 *1, 2009*):

1103 (a) The Commissioner of Social Services shall implement a state
1104 medical assistance component of the state-administered general
1105 assistance program for persons ineligible for Medicaid. Eligibility
1106 criteria concerning income shall be the same as the medically needy
1107 component of the Medicaid program as utilized on June 30, 2009,
1108 except that earned monthly gross income of up to one hundred fifty
1109 dollars shall be disregarded. Unearned income shall not be
1110 disregarded. No person who has family assets exceeding one thousand
1111 dollars shall be eligible. No person shall be eligible for assistance
1112 under this section if such person made, during the three months prior
1113 to the month of application, an assignment or transfer or other
1114 disposition of property for less than fair market value. The number of
1115 months of ineligibility due to such disposition shall be determined by
1116 dividing the fair market value of such property, less any consideration
1117 received in exchange for its disposition, by five hundred dollars. Such
1118 period of ineligibility shall commence in the month in which the
1119 person is otherwise eligible for benefits. Any assignment, transfer or
1120 other disposition of property, on the part of the transferor, shall be
1121 presumed to have been made for the purpose of establishing eligibility
1122 for benefits or services unless such person provides convincing
1123 evidence to establish that the transaction was exclusively for some

1124 other purpose.

1125 Sec. 23. Section 17b-261 of the general statutes is amended by
1126 adding subsections (j) and (k) as follows (*Effective July 1, 2009*):

1127 (NEW) (j) Notwithstanding the provisions of this section, the
1128 Commissioner of Social Services, pursuant to 42 USC 1396a(r)(2), shall
1129 file an amendment to the Medicaid state plan that allows said
1130 commissioner, when making Medicaid income eligibility
1131 determinations, to establish a special income disregard applicable only
1132 to the Medicaid program that permits individuals who are aged, blind
1133 or disabled and who have income that is not greater than one hundred
1134 per cent of the federal poverty level to qualify for Medicaid.

1135 (NEW) (k) To the extent permitted by federal law, the
1136 Commissioner of Social Services may impose copayments on persons
1137 eligible for medical assistance under the provisions of this section who
1138 utilize the emergency room of a hospital to access services of a
1139 nonemergency nature. Services of a nonemergency nature shall be
1140 defined by the commissioner after consultation with representative
1141 staff of emergency rooms throughout the state. Prior to imposing any
1142 such copayments, the commissioner shall provide not less than thirty
1143 days written notice to all persons eligible for medical assistance under
1144 this section advising such persons of the impending implementation of
1145 copayments and the Department of Social Services' policies that will be
1146 applicable to such copayments. The first instance of emergency room
1147 use by an eligible person to access services of a nonemergency nature
1148 shall not result in the imposition of a copayment, but the staff at such
1149 emergency room shall provide verbal and written notice, in a manner
1150 prescribed by the commissioner, that advises such person that
1151 continued use of the emergency room for services of a nonemergency
1152 nature shall result in the imposition of copayments on the recipient
1153 and that such person should seek nonemergency care from other
1154 providers assigned to provide medical assistance to such person in
1155 accordance with the provisions of this section. Any copayment

1156 imposed pursuant to this subsection shall not exceed the sum of
1157 twenty-five dollars per visit and the hospital shall have the discretion
1158 to waive collection of the copayment based on a determination of
1159 hardship or otherwise. The commissioner shall not deduct any
1160 copayment imposed pursuant to this subsection from payments that
1161 are due and owing from the department to such emergency room.

1162 Sec. 24. Section 17b-292 of the general statutes is repealed and the
1163 following is substituted in lieu thereof (*Effective July 1, 2009*):

1164 (a) A child who resides in a household with a family income which
1165 exceeds one hundred eighty-five per cent of the federal poverty level
1166 and does not exceed three hundred per cent of the federal poverty
1167 level may be eligible for subsidized benefits under the HUSKY Plan,
1168 Part B.

1169 (b) A child who resides in a household with a family income over
1170 three hundred per cent of the federal poverty level may be eligible for
1171 unsubsidized benefits under the HUSKY Plan, Part B.

1172 (c) Whenever a court or family support magistrate orders a
1173 noncustodial parent to provide health insurance for a child, such
1174 parent may provide for coverage under the HUSKY Plan, Part B.

1175 (d) On and after January 1, 2010, a child who is determined to be
1176 eligible for benefits under either the HUSKY Plan, Part A or Part B,
1177 shall remain eligible for such plan for a period of twelve months from
1178 such child's determination of eligibility unless the child attains the age
1179 of nineteen or is no longer a resident of the state. An adult who is
1180 determined to be eligible for benefits under the HUSKY Plan, Part A
1181 shall, unless otherwise precluded under federal law, remain eligible
1182 for such plan for a period of twelve months from such adult's
1183 determination of eligibility unless the adult is no longer a resident of
1184 the state. During the twelve-month period following the date that an
1185 adult or child is determined eligible for the HUSKY Plan, Part A or
1186 Part B, the adult or family of such child shall comply with federal

1187 requirements concerning the reporting of information to the
1188 department, including, but not limited to, change of address
1189 information.

1190 [(d)] (e) To the extent allowed under federal law, the commissioner
1191 shall not pay for services or durable medical equipment under the
1192 HUSKY Plan, Part B if the enrollee has other insurance coverage for
1193 the services or such equipment.

1194 [(e)] (f) A newborn child who otherwise meets the eligibility criteria
1195 for the HUSKY Plan, Part B shall be eligible for benefits retroactive to
1196 his or her date of birth, provided an application is filed on behalf of the
1197 child not later than thirty days after such date. Any uninsured child
1198 born in a hospital in this state or in a border state hospital shall be
1199 enrolled on an expedited basis in the HUSKY Plan, Part B, provided (1)
1200 the parent or caretaker relative of such child resides in this state, and
1201 (2) the parent or caretaker relative of such child authorizes enrollment
1202 in the program. The commissioner shall pay any premium cost such
1203 family would otherwise incur for the first four months of coverage to
1204 the managed care organization selected by the parent or caretaker
1205 relative to provide coverage for such child.

1206 [(f)] (g) The commissioner shall implement presumptive eligibility
1207 for children applying for Medicaid. Such presumptive eligibility
1208 determinations shall be in accordance with applicable federal law and
1209 regulations. The commissioner shall adopt regulations, in accordance
1210 with chapter 54, to establish standards and procedures for the
1211 designation of organizations as qualified entities to grant presumptive
1212 eligibility. Qualified entities shall ensure that, at the time a
1213 presumptive eligibility determination is made, a completed application
1214 for Medicaid is submitted to the department for a full eligibility
1215 determination. In establishing such standards and procedures, the
1216 commissioner shall ensure the representation of state-wide and local
1217 organizations that provide services to children of all ages in each
1218 region of the state.

1219 [(g)] (h) The commissioner shall provide for a single point of entry
1220 servicer for applicants and enrollees under the HUSKY Plan, Part A
1221 and Part B. The commissioner, in consultation with the servicer, shall
1222 establish a centralized unit to be responsible for processing all
1223 applications for assistance under the HUSKY Plan, Part A and Part B.
1224 The department, through its servicer, shall ensure that a child who is
1225 determined to be eligible for benefits under the HUSKY Plan, Part A,
1226 or the HUSKY Plan, Part B has uninterrupted health insurance
1227 coverage for as long as the parent or guardian elects to enroll or re-
1228 enroll such child in the HUSKY Plan, Part A or Part B. The
1229 commissioner, in consultation with the servicer, and in accordance
1230 with the provisions of section 17b-297, shall jointly market both Part A
1231 and Part B together as the HUSKY Plan and shall develop and
1232 implement public information and outreach activities with community
1233 programs. Such servicer shall electronically transmit data with respect
1234 to enrollment and disenrollment in the HUSKY Plan, Part A and Part B
1235 to the commissioner.

1236 [(h)] (i) Upon the expiration of any contractual provisions entered
1237 into pursuant to subsection [(g)] (h) of this section, the commissioner
1238 shall develop a new contract for single point of entry services and
1239 managed care enrollment brokerage services. The commissioner may
1240 enter into one or more contractual arrangements for such services for a
1241 contract period not to exceed seven years. Such contracts shall include
1242 performance measures, including, but not limited to, specified time
1243 limits for the processing of applications, parameters setting forth the
1244 requirements for a completed and reviewable application and the
1245 percentage of applications forwarded to the department in a complete
1246 and timely fashion. Such contracts shall also include a process for
1247 identifying and correcting noncompliance with established
1248 performance measures, including sanctions applicable for instances of
1249 continued noncompliance with performance measures.

1250 [(i)] (j) The single point of entry servicer shall send all applications
1251 and supporting documents to the commissioner for determination of

1252 eligibility. The servicer shall enroll eligible beneficiaries in the
1253 applicant's choice of managed care plan. Upon enrollment in a
1254 managed care plan, an eligible HUSKY Plan Part A or Part B
1255 beneficiary shall remain enrolled in such managed care plan for twelve
1256 months from the date of such enrollment unless (1) an eligible
1257 beneficiary demonstrates good cause to the satisfaction of the
1258 commissioner of the need to enroll in a different managed care plan, or
1259 (2) the beneficiary no longer meets program eligibility requirements.

1260 [(j)] (k) Not later than ten months after the determination of
1261 eligibility for benefits under the HUSKY Plan, Part A and Part B and
1262 annually thereafter, the commissioner or the servicer, as the case may
1263 be, shall within existing budgetary resources, mail or, upon request of
1264 a participant, electronically transmit an application form to each
1265 participant in the plan for the purposes of obtaining information to
1266 make a determination on continued eligibility beyond the twelve
1267 months of initial eligibility. To the extent permitted by federal law, in
1268 determining eligibility for benefits under the HUSKY Plan, Part A or
1269 Part B with respect to family income, the commissioner or the servicer
1270 shall rely upon information provided in such form by the participant
1271 unless the commissioner or the servicer has reason to believe that such
1272 information is inaccurate or incomplete. The Department of Social
1273 Services shall annually review a random sample of cases to confirm
1274 that, based on the statistical sample, relying on such information is not
1275 resulting in ineligible clients receiving benefits under HUSKY Plan
1276 Part A or Part B. The determination of eligibility shall be coordinated
1277 with health plan open enrollment periods.

1278 [(k)] (l) The commissioner shall implement the HUSKY Plan, Part B
1279 while in the process of adopting necessary policies and procedures in
1280 regulation form in accordance with the provisions of section 17b-10.

1281 [(l)] (m) The commissioner shall adopt regulations, in accordance
1282 with chapter 54, to establish residency requirements and income
1283 eligibility for participation in the HUSKY Plan, Part B and procedures

1284 for a simplified mail-in application process. Notwithstanding the
1285 provisions of section 17b-257b, such regulations shall provide that any
1286 child adopted from another country by an individual who is a citizen
1287 of the United States and a resident of this state shall be eligible for
1288 benefits under the HUSKY Plan, Part B upon arrival in this state.

1289 Sec. 25. Section 17b-267 of the general statutes is repealed and the
1290 following is substituted in lieu thereof (*Effective July 1, 2010*):

1291 (a) If any group or association of providers of medical assistance
1292 services wishes to have payments as provided for under sections 17b-
1293 260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to
1294 17b-361, inclusive, to such providers made through a national, state or
1295 other public or private agency or organization and nominates such
1296 agency or organization for this purpose, the Commissioner of Social
1297 Services is authorized to enter into an agreement with such agency or
1298 organization providing for the determination by such agency or
1299 organization, subject to such review by the Commissioner of Social
1300 Services as may be provided for by the agreement, of the payments
1301 required to be made to such providers at the rates set by the hospital
1302 cost commission, and for the making of such payments by such agency
1303 or organization to such providers. Such agreement may also include
1304 provision for the agency or organization to do all or any part of the
1305 following: With respect to the providers of services which are to
1306 receive payments through it, (1) to serve as a center for, and to
1307 communicate to providers, any information or instructions furnished
1308 to it by the Commissioner of Social Services, and to serve as a channel
1309 of communication from providers to the Commissioner of Social
1310 Services; (2) to make such audits of the records of providers as may be
1311 necessary to insure that proper payments are made under this section;
1312 and (3) to perform such other functions as are necessary to carry out
1313 the provisions of sections 17b-267 to 17b-271, inclusive, as amended by
1314 this act.

1315 (b) The Commissioner of Social Services shall not enter into an

1316 agreement with any agency or organization under subsection (a) of
1317 this section unless (1) he finds (A) that to do so is consistent with the
1318 effective and efficient administration of the medical assistance
1319 program, and (B) that such agency or organization is willing and able
1320 to assist the providers to which payments are made through it in the
1321 application of safeguards against unnecessary utilization of services
1322 furnished by them to individuals entitled to hospital insurance benefits
1323 under section 17b-261, as amended by this act, and the agreement
1324 provides for such assistance, and (2) such agency or organization
1325 agrees to furnish to the Commissioner of Social Services such of the
1326 information acquired by it in carrying out its agreement under sections
1327 17b-267 to 17b-271, inclusive, as amended by this act, as the
1328 Commissioner of Social Services may find necessary in performing his
1329 functions under said sections.

1330 (c) An agreement with any agency or organization under subsection
1331 (a) of this section may contain such terms and conditions as the
1332 Commissioner of Social Services finds necessary or appropriate, may
1333 provide for advances of funds to the agency or organization for the
1334 making of payments by it under said subsection (a), and shall provide
1335 for payment by the Commissioner of Social Services of so much of the
1336 cost of administration of the agency or organization as is determined
1337 by the Commissioner of Social Services to be necessary and proper for
1338 carrying out the functions covered by the agreement.

1339 (d) Each managed care plan that enters into, renews or amends a
1340 contract with the Department of Social Services pursuant to this
1341 section shall limit its administrative costs to ten per cent of payments
1342 made pursuant to such contracts. The Commissioner of Social Services
1343 shall implement policies and procedures to effectuate the purpose of
1344 this subsection while in the process of adopting such policies or
1345 procedures in regulation form, provided notice of intention to adopt
1346 the regulations is printed in the Connecticut Law Journal not later than
1347 twenty days after implementation and any such policies and
1348 procedures shall be valid until the time the regulations are effective.

1349 The Commissioner of Social Services may define administrative costs
1350 to exclude disease management or other value-added clinical
1351 programs administered by the managed care plans, but not to exclude
1352 utilization management, claims, member services or other nonclinical
1353 functions.

1354 Sec. 26. (NEW) (*Effective July 1, 2009*) To the extent permitted by
1355 federal law, any employer in the state that offers health care benefits to
1356 its employees shall offer benefits or premium contributions that are
1357 equivalent in value to all such employees regardless of any differential
1358 in the amount of compensation paid to such employees. Nothing in
1359 this section shall preclude an employer from offering employees with a
1360 lower amount of compensation a more comprehensive health care
1361 benefit plan or a higher level of employer premium contribution than
1362 offered to employees receiving a higher amount of compensation.

1363 Sec. 27. (NEW) (*Effective January 1, 2011, and applicable to income years*
1364 *commencing on or after January 1, 2011*) (a) For purposes of this section:

1365 (1) "Employer" means any person, firm, business, educational
1366 institution, nonprofit agency, corporation, limited liability company or
1367 any other business entity which, on at least fifty per cent of its working
1368 days during the preceding twelve months, (A) employed ten or fewer
1369 employees in the state, (B) employed eleven to fifty employees in the
1370 state, of whom at least thirty per cent were paid annualized wages by
1371 the employer equal to or less than three hundred per cent of the
1372 federal poverty level for a family of three, or (C) employed more than
1373 fifty employees in the state, at least seventy-five per cent of whom
1374 were paid annualized wages by the employer equal to or less than one
1375 hundred eighty-five per cent of the federal poverty level for a family of
1376 three;

1377 (2) "Full-time employee" means any person employed in or residing
1378 in this state, who is not a temporary or seasonal employee, employed
1379 by an employer and required to work a minimum of thirty-five hours
1380 per week; and

1381 (3) "Part-time employee" means any person employed in or residing
1382 in this state, who is not a temporary or seasonal employee, employed
1383 by an employer and required to work less than thirty-five hours per
1384 week.

1385 (b) (1) There is established a tax credit program to assist employers
1386 with providing health insurance to their employees to achieve the goal
1387 of ensuring greater access to health insurance for residents of this state.
1388 Any employer that elects to claim a tax credit pursuant to this section
1389 shall submit to the Connecticut Connector, as established in section 3
1390 of this act, a copy of such employer's health insurance plan,
1391 documentation of employees' wages and proof of such employer's
1392 premium contributions. If the Health Reinsurance Association, on
1393 behalf of the Connecticut Connector, certifies that such plan meets or
1394 exceeds the type and level of benefits of the Affordable Health Care
1395 Plans established pursuant to section 2 of this act, the Health
1396 Reinsurance Association shall issue a certificate indicating such fact.

1397 (2) To qualify for a tax credit pursuant to this section, an employer
1398 shall (A) obtain a certificate from the Connecticut Connector in
1399 accordance with this section, and (B) pay a minimum of seventy per
1400 cent of the cost of an employee's health care benefits or a minimum of
1401 fifty per cent of the cost of an employee plus dependents' health care
1402 benefits for full-time employees.

1403 (c) An employer shall be allowed a tax credit against the tax
1404 imposed under chapter 208 of the general statutes for income years
1405 commencing on or after January 1, 2011, in the following amounts:

1406 (1) For employers offering such coverage to all full-time employees
1407 but not part-time employees, the credit shall be in an amount equal to
1408 twenty per cent of the cost of providing health care benefits, provided
1409 such amount shall not exceed eight hundred dollars per employee per
1410 year in the case of a policy covering an individual employee, one
1411 thousand six hundred dollars per employee per year in the case of a
1412 policy covering an employee and only one other individual, or two

1413 thousand four hundred dollars per employee per year in the case of a
1414 policy covering an employee and the family of such employee;

1415 (2) For employers offering such coverage to all full-time and part-
1416 time employees, the credit shall be in an amount equal to thirty per
1417 cent of the cost of providing health care benefits, provided such
1418 amount shall not exceed one thousand two hundred dollars per
1419 employee per year in the case of a policy covering an individual
1420 employee, two thousand four hundred dollars per employee per year
1421 in the case of a policy covering an employee and only one other
1422 individual, or three thousand six hundred dollars per employee per
1423 year in the case of a policy covering an employee and the family of
1424 such employee.

1425 (d) An employer qualifying under subsection (b) of this section that
1426 is a limited liability company, limited liability partnership, limited
1427 partnership or S corporation, as defined in section 12-284b of the
1428 general statutes, may distribute a credit to its members and such
1429 members shall be eligible to use such credit against the tax imposed
1430 under chapter 229 of the general statutes. The total credit that may be
1431 distributed shall not be greater than the following:

1432 (1) For employers offering such coverage to all full-time employees
1433 but not part-time employees, the credit shall be in an amount equal to
1434 twenty per cent of the cost of providing health benefits, provided such
1435 amount shall not exceed eight hundred dollars per employee per year
1436 in the case of a policy covering an individual employee, one thousand
1437 six hundred dollars per employee per year in the case of a policy
1438 covering an employee and only one other individual, or two thousand
1439 four hundred dollars per employee per year in the case of a policy
1440 covering the employee and the family of such employee;

1441 (2) For employers offering such coverage to all full-time and part-
1442 time employees, the credit shall be in an amount equal to thirty per
1443 cent of the cost of providing health benefits, provided such amount
1444 shall not exceed one thousand two hundred dollars per employee per

1445 year in the case of a policy covering an individual employee, two
1446 thousand four hundred dollars per employee per year in the case of a
1447 policy covering an employee and only one other individual, or three
1448 thousand six hundred dollars per employee per year in the case of a
1449 policy covering an employee and the family of such employee.

1450 (e) (1) In the event the employer owes less than the value of the
1451 credit allowed under subsection (c) of this section, the employer shall
1452 be entitled to a refund from the state in an amount equal to the amount
1453 of the unused credit.

1454 (2) In the event the individual claiming a credit under subsection (d)
1455 of this section owes less than the value of the credit allowed under said
1456 subsection, the individual shall be entitled to a refund from the state in
1457 an amount equal to the amount of the unused credit.

1458 (f) The dollar amount of the credits in subsections (c) and (d) of this
1459 section shall be annually indexed to the consumer price index for
1460 medical care.

1461 Sec. 28. Section 38a-556 of the general statutes is repealed and the
1462 following is substituted in lieu thereof (*Effective July 1, 2009*):

1463 There is hereby created a nonprofit legal entity to be known as the
1464 Health Reinsurance Association. All insurers, health care centers and
1465 self-insurers doing business in the state, as a condition to their
1466 authority to transact the applicable kinds of health insurance defined
1467 in section 38a-551 and under sections 3 and 4 of this act, shall be
1468 members of the association. The association shall perform its functions
1469 under a plan of operation established and approved under subdivision
1470 (a) of this section, and shall exercise its powers through a board of
1471 directors established under this section.

1472 (a) (1) The board of directors of the association shall be made up of
1473 nine individuals selected by participating members, subject to
1474 approval by the commissioner, two of whom shall be appointed by the

1475 commissioner on or before July 1, 1993, to represent health care
1476 centers. To select the initial board of directors, and to initially organize
1477 the association, the commissioner shall give notice to all members of
1478 the time and place of the organizational meeting. In determining
1479 voting rights at the organizational meeting each member shall be
1480 entitled to vote in person or proxy. The vote shall be a weighted vote
1481 based upon the net health insurance premium derived from this state
1482 in the previous calendar year. If the board of directors is not selected
1483 within sixty days after notice of the organizational meeting, the
1484 commissioner may appoint the initial board. In approving or selecting
1485 members of the board, the commissioner may consider, among other
1486 things, whether all members are fairly represented. Members of the
1487 board may be reimbursed from the moneys of the association for
1488 expenses incurred by them as members, but shall not otherwise be
1489 compensated by the association for their services. (2) The board shall
1490 submit to the commissioner a plan of operation for the association
1491 necessary or suitable to assure the fair, reasonable and equitable
1492 administration of the association. The plan of operation shall become
1493 effective upon approval in writing by the commissioner consistent
1494 with the date on which the coverage under sections 38a-505, 38a-546,
1495 [and] 38a-551 to 38a-559, inclusive, and under sections 3 and 4 of this
1496 act, must be made available. The commissioner shall, after notice and
1497 hearing, approve the plan of operation provided such plan is
1498 determined to be suitable to assure the fair, reasonable and equitable
1499 administration of the association, and provides for the sharing of
1500 association gains or losses on an equitable proportionate basis. If the
1501 board fails to submit a suitable plan of operation within one hundred
1502 eighty days after its appointment, or if at any time thereafter the board
1503 fails to submit suitable amendments to the plan, the commissioner
1504 shall, after notice and hearing, adopt and promulgate such reasonable
1505 rules as are necessary or advisable to effectuate the provisions of this
1506 section. Such rules shall continue in force until modified by the
1507 commissioner or superseded by a plan submitted by the board and
1508 approved by the commissioner. The plan of operation shall, in addition

1509 to requirements enumerated in sections 38a-505, 38a-546 and 38a-551
1510 to 38a-559, inclusive: (A) Establish procedures for the handling and
1511 accounting of assets and moneys of the association; (B) establish
1512 regular times and places for meetings of the board of directors; (C)
1513 establish procedures for records to be kept of all financial transactions,
1514 and for the annual fiscal reporting to the commissioner; (D) establish
1515 procedures whereby selections for the board of directors shall be made
1516 and submitted to the commissioner; (E) establish procedures to amend,
1517 subject to the approval of the commissioner, the plan of operations; (F)
1518 establish procedures for the selection of an administering carrier and
1519 set forth the powers and duties of the administering carrier; (G)
1520 contain additional provisions necessary or proper for the execution of
1521 the powers and duties of the association; (H) establish procedures for
1522 the advertisement on behalf of all participating carriers of the general
1523 availability of the comprehensive coverage under sections 38a-505,
1524 38a-546 and 38a-551 to 38a-559, inclusive; (I) contain additional
1525 provisions necessary for the association to qualify as an acceptable
1526 alternative mechanism in accordance with Section 2744 of the Public
1527 Health Service Act, as set forth in the Health Insurance Portability and
1528 Accountability Act of 1996, [(P.L. 104-191)] P.L. 104-191, as amended
1529 from time to time; and (J) contain additional provisions necessary for
1530 the association to qualify as acceptable coverage in accordance with
1531 the Pension Benefit Guaranty Corporation and Trade Adjustment
1532 Assistance programs of the Trade Act of 2002, [(P.L. 107-210)] P.L. 107-
1533 210, as amended from time to time. The commissioner may adopt
1534 regulations, in accordance with the provisions of chapter 54, to
1535 establish criteria for the association to qualify as an acceptable
1536 alternative mechanism.

1537 (b) The association shall have the general powers and authority
1538 granted under the laws of this state to carriers to transact the kinds of
1539 insurance defined under section 38a-551, and in addition thereto, the
1540 specific authority to: (1) Enter into contracts necessary or proper to
1541 carry out the provisions and purposes of sections 38a-505, 38a-546,
1542 [and] 38a-551 to 38a-559, inclusive, and under sections 3 and 4 of this

1543 act; (2) sue or be sued, including taking any legal actions necessary or
1544 proper for recovery of any assessments for, on behalf of, or against
1545 participating members; (3) take such legal action as necessary to avoid
1546 the payment of improper claims against the association or the coverage
1547 provided by or through the association; (4) establish, with respect to
1548 health insurance provided by or on behalf of the association,
1549 appropriate rates, scales of rates, rate classifications and rating
1550 adjustments, such rates not to be unreasonable in relation to the
1551 coverage provided and the operational expenses of the association; (5)
1552 administer any type of reinsurance program, for or on behalf of
1553 participating members; (6) pool risks among participating members;
1554 (7) issue policies of insurance on an indemnity or provision of service
1555 basis providing the coverage required by sections 38a-505, 38a-546 and
1556 38a-551 to 38a-559, inclusive, in its own name or on behalf of
1557 participating members; (8) administer separate pools, separate
1558 accounts or other plans as deemed appropriate for separate members
1559 or groups of members; (9) operate and administer any combination of
1560 plans, pools, reinsurance arrangements or other mechanisms as
1561 deemed appropriate to best accomplish the fair and equitable
1562 operation of the association; (10) set limits on the amounts of
1563 reinsurance which may be ceded to the association by its members;
1564 (11) appoint from among participating members appropriate legal,
1565 actuarial and other committees as necessary to provide technical
1566 assistance in the operation of the association, policy and other contract
1567 design, and any other function within the authority of the association;
1568 and (12) apply for and accept grants, gifts and bequests of funds from
1569 other states, federal and interstate agencies and independent
1570 authorities, private firms, individuals and foundations for the purpose
1571 of carrying out its responsibilities. Any such funds received shall be
1572 deposited in the General Fund and shall be credited to a separate
1573 nonlapsing account within the General Fund for the Health
1574 Reinsurance Association and may be used by the Health Reinsurance
1575 Association in the performance of its duties.

1576 (c) Every member shall participate in the association in accordance

1577 with the provisions of this subdivision. (1) A participating member
1578 shall determine the particular risks it elects to have written by or
1579 through the association. A member shall designate which of the
1580 following classes of risks it shall underwrite in the state, from which
1581 classes of risk it may elect to reinsure selected risks: (A) Individual,
1582 excluding group conversion; and (B) individual, including group
1583 conversion. (2) No member shall be permitted to select out individual
1584 lives from an employer group to be insured by or through the
1585 association. Members electing to administer risks which are insured by
1586 or through the association shall comply with the benefit determination
1587 guidelines and the accounting procedures established by the
1588 association. A risk insured by or through the association cannot be
1589 withdrawn by the participating member except in accordance with the
1590 rules established by the association. (3) Rates for coverage issued by or
1591 through the association shall not be excessive, inadequate or unfairly
1592 discriminatory. Separate scales of premium rates based on age shall
1593 apply, but rates shall not be adjusted for area variations in provider
1594 costs. Premium rates shall take into consideration the substantial extra
1595 morbidity and administrative expenses for association risks,
1596 reimbursement or reasonable expenses incurred for the writing of
1597 association risks and the level of rates charged by insurers for groups
1598 of ten lives, provided incurred losses which result from provision of
1599 coverage in accordance with section 38a-537 shall not be considered. In
1600 no event shall the rate for a given classification or group be less than
1601 one hundred twenty-five per cent or more than one hundred fifty per
1602 cent of the average rate charged for that classification with similar
1603 characteristics under a policy covering ten lives. All rates shall be
1604 promulgated by the association through an actuarial committee
1605 consisting of five persons who are members of the American Academy
1606 of Actuaries, shall be filed with the commissioner and may be
1607 disapproved [within] not later than sixty days [from] after the filing
1608 thereof if excessive, inadequate or unfairly discriminatory.

1609 (d) (1) Following the close of each fiscal year, the administering
1610 carrier shall determine the net premiums, reinsurance premiums less

1611 administrative expense allowance, the expense of administration
1612 pertaining to the reinsurance operations of the association and the
1613 incurred losses for the year. Any net loss shall be assessed to all
1614 participating members in proportion to their respective shares of the
1615 total health insurance premiums earned in this state during the
1616 calendar year, or with paid losses in the year, coinciding with or
1617 ending during the fiscal year of the association or on any other
1618 equitable basis as may be provided in the plan of operations. For self-
1619 insured members of the association, health insurance premiums
1620 earned shall be established by dividing the amount of paid health
1621 losses for the applicable period by eighty-five per cent. Net gains, if
1622 any, shall be held at interest to offset future losses or allocated to
1623 reduce future premiums. (2) Any net loss to the association
1624 represented by the excess of its actual expenses of administering
1625 policies issued by the association over the applicable expense
1626 allowance shall be separately assessed to those participating members
1627 who do not elect to administer their plans. All assessments shall be on
1628 an equitable formula established by the board. (3) The association shall
1629 conduct periodic audits to assure the general accuracy of the financial
1630 data submitted to the association and the association shall have an
1631 annual audit of its operations by an independent certified public
1632 accountant. The annual audit shall be filed with the commissioner for
1633 his review and the association shall be subject to the provisions of
1634 section 38a-14. (4) For the fiscal year ending December 31, 1993, and
1635 the first quarter of the fiscal year ending December 31, 1994, the
1636 administering carrier shall not include health care centers in assessing
1637 any net losses to participating members.

1638 (e) All policy forms issued by or through the association shall
1639 conform in substance to prototype forms developed by the association,
1640 shall in all other respects conform to the requirements of sections 38a-
1641 505, 38a-546 and 38a-551 to 38a-559, inclusive, and shall be approved
1642 by the commissioner. The commissioner may disapprove any such
1643 form if it contains a provision or provisions which are unfair or
1644 deceptive or which encourage misrepresentation of the policy.

1645 (f) Unless otherwise permitted by the plan of operation, the
1646 association shall not issue, reissue or continue in force comprehensive
1647 health care plan coverage with respect to any person who is already
1648 covered under an individual or group comprehensive health care plan,
1649 or who is sixty-five years of age or older and eligible for Medicare or
1650 who is not a resident of this state. Coverage provided to a HIPAA or
1651 health care tax credit eligible individual may be terminated to the
1652 extent permitted by [HIPAA] the Health Insurance Portability and
1653 Accountability Act of 1996, P.L. 104-191, as amended from time to
1654 time, or the Trade Act of 2002, P.L. 107-210, as amended from time to
1655 time, respectively.

1656 (g) Benefits payable under a comprehensive health care plan
1657 insured by or reinsured through the association shall be paid net of all
1658 other health insurance benefits paid or payable through any other
1659 source, and net of all health insurance coverages provided by or
1660 pursuant to any other state or federal law including Title XVIII of the
1661 Social Security Act, Medicare, but excluding Medicaid.

1662 (h) There shall be no liability on the part of and no cause of action of
1663 any nature shall arise against any carrier or its agents or its employees,
1664 the Health Reinsurance Association or its agents or its employees or
1665 the residual market mechanism established under the provisions of
1666 section 38a-557 or its agents or its employees, or the commissioner or
1667 his representatives for any action taken by them in the performance of
1668 their duties under sections 38a-505, 38a-546, [and] 38a-551 to 38a-559,
1669 inclusive, and under sections 3 and 4 of this act. This provision shall
1670 not apply to the obligations of a carrier, a self-insurer, the Health
1671 Reinsurance Association or the residual market mechanism for
1672 payment of benefits provided under a comprehensive health care plan.

1673 Sec. 29. (*Effective July 1, 2009*) Notwithstanding the provisions of
1674 section 4-28e of the general statutes, the sum of two million dollars
1675 shall be transferred from the Tobacco and Health Trust Fund to the
1676 General Fund, to be used by the Department of Public Health for the

1677 Connecticut Tobacco Use Prevention and Control Plan.

1678 Sec. 30. (*Effective July 1, 2009*) The sum of one million dollars is
1679 appropriated to the Department of Public Health, from the General
1680 Fund, for the fiscal year ending June 30, 2010, to expand the
1681 Connecticut Tobacco Use Prevention and Control Plan to cover
1682 smoking cessation medication and supplies, including, but not limited
1683 to, nicotine replacement therapy.

1684 Sec. 31. (*Effective July 1, 2009*) The sum of one million six hundred
1685 thousand dollars is appropriated to the Department of Public Health,
1686 from the General Fund, for the fiscal year ending June 30, 2010, for the
1687 purpose of providing grants to be awarded on July 1, 2010, in the
1688 amount of two hundred thousand dollars to eight different groups
1689 representing the interests of Connecticut employers. The
1690 Commissioner of Public Health, in accordance with the provisions of
1691 chapter 54 of the general statutes, shall establish the criteria and
1692 procedures used to select said groups. Such grants shall be used to
1693 train employers to effectively educate employees concerning the
1694 financial and health benefits of making lifestyle choices that promote
1695 good health, including maintaining a healthy weight and regular
1696 exercise.

1697 Sec. 32. (*Effective July 1, 2009*) The sum of one million dollars is
1698 appropriated to the Department of Social Services, from the General
1699 Fund, for the fiscal year ending June 30, 2010, for the purpose of
1700 obtaining consultant services to assist said department in the
1701 implementation of section 19 of this act.

1702 Sec. 33. (*Effective July 1, 2009*) The sum of ____ dollars is
1703 appropriated to the Office of Health Care Access, from the General
1704 Fund, for the fiscal year ending June 30, 2010, for the purposes of
1705 section 8 of this act.

1706 Sec. 34. (*Effective July 1, 2009*) The sum of ____ dollars is
1707 appropriated to the Office of Health Care Access, from the General

1708 Fund, for the fiscal year ending June 30, 2010, for the purposes of
1709 section 9 of this act.

1710 Sec. 35. (*Effective July 1, 2009*) The sum of five hundred thousand
1711 dollars is appropriated to the Office of Health Care Access, from the
1712 General Fund, for the fiscal year ending June 30, 2010, for the purposes
1713 of the Health Care Reform Commission established under section 2 of
1714 this act.

1715 Sec. 36. (*Effective July 1, 2009*) The sum of five hundred thousand
1716 dollars is appropriated to the Office of Health Care Access, from the
1717 General Fund, for the fiscal year ending June 30, 2010, for the purpose
1718 of providing one-time start-up funds for the establishment of the
1719 Connecticut Health Quality Partnership pursuant to section 14 of this
1720 act, which shall be contingent upon the partnership obtaining a
1721 commitment by six or more members to contribute dues sufficient to
1722 assure the financial viability of the organization.

1723 Sec. 37. (*Effective July 1, 2009*) The sum of two hundred thousand
1724 dollars is appropriated to the Office of Health Care Access, from the
1725 General Fund, for the fiscal year ending June 30, 2010, for the purpose
1726 of conducting the study and survey as required by section 15 of this
1727 act.

1728 Sec. 38. (*Effective July 1, 2009*) The sum of two hundred fifty
1729 thousand dollars is appropriated to the Office of Health Care Access,
1730 from the General Fund, for the fiscal year ending June 30, 2010, for the
1731 purposes of the subcommittee on healthy lifestyles established under
1732 section 13 of this act.

1733 Sec. 39. (*Effective July 1, 2010*) The sum of two hundred sixty
1734 thousand dollars is appropriated to the Office of Health Care Access,
1735 from the General Fund, for the fiscal year ending June 30, 2011, for the
1736 purposes of the subcommittee on healthy lifestyles established under
1737 section 13 of this act.

1738 Sec. 40. (*Effective July 1, 2009*) The sum of one million dollars is
 1739 appropriated to the Insurance Department, from the General Fund, for
 1740 the fiscal year ending June 30, 2010, for the purpose of providing start-
 1741 up costs for the Connecticut Connector including, but not limited to,
 1742 web site development, a premium subsidy administration system,
 1743 marketing, communications, administrative functions, and purchase of
 1744 other technology and equipment to facilitate and streamline operation
 1745 and administration of the Connecticut Connector established under
 1746 section 3 of this act.

1747 Sec. 41. (*Effective July 1, 2009*) (a) The sum of one million five
 1748 hundred thousand dollars is appropriated to the Insurance
 1749 Department, from the General Fund, for the fiscal year ending June 30,
 1750 2010, to operate and administer the Connecticut Connector established
 1751 under section 3 of this act, and to market the affordable health care
 1752 plans.

1753 (b) The sum of one million dollars is appropriated to the Insurance
 1754 Department, from the General Fund, for the fiscal year ending June 30,
 1755 2011, to operate and administer the Connecticut Connector established
 1756 under section 3 of this act, and to market the affordable health care
 1757 plans.

1758 Sec. 42. Section 17b-261c of the general statutes is repealed. (*Effective*
 1759 *January 1, 2010*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2009</i>	New section
Sec. 2	<i>July 1, 2009</i>	New section
Sec. 3	<i>July 1, 2009</i>	New section
Sec. 4	<i>January 1, 2011</i>	New section
Sec. 5	<i>January 1, 2011</i>	New section
Sec. 6	<i>January 1, 2011</i>	New section
Sec. 7	<i>October 1, 2009</i>	New section
Sec. 8	<i>October 1, 2010</i>	New section

Sec. 9	<i>October 1, 2010</i>	New section
Sec. 10	<i>January 1, 2010</i>	38a-567
Sec. 11	<i>July 1, 2009</i>	New section
Sec. 12	<i>July 1, 2009</i>	New section
Sec. 13	<i>January 1, 2010</i>	New section
Sec. 14	<i>July 1, 2009</i>	New section
Sec. 15	<i>October 1, 2009</i>	New section
Sec. 16	<i>July 1, 2009</i>	New section
Sec. 17	<i>July 1, 2009</i>	New section
Sec. 18	<i>July 1, 2009</i>	New section
Sec. 19	<i>July 1, 2009</i>	New section
Sec. 20	<i>July 1, 2009</i>	New section
Sec. 21	<i>July 1, 2009</i>	New section
Sec. 22	<i>July 1, 2009</i>	17b-192(a)
Sec. 23	<i>July 1, 2009</i>	17b-261
Sec. 24	<i>July 1, 2009</i>	17b-292
Sec. 25	<i>July 1, 2010</i>	17b-267
Sec. 26	<i>July 1, 2009</i>	New section
Sec. 27	<i>January 1, 2011, and applicable to income years commencing on or after January 1, 2011</i>	New section
Sec. 28	<i>July 1, 2009</i>	38a-556
Sec. 29	<i>July 1, 2009</i>	New section
Sec. 30	<i>July 1, 2009</i>	New section
Sec. 31	<i>July 1, 2009</i>	New section
Sec. 32	<i>July 1, 2009</i>	New section
Sec. 33	<i>July 1, 2009</i>	New section
Sec. 34	<i>July 1, 2009</i>	New section
Sec. 35	<i>July 1, 2009</i>	New section
Sec. 36	<i>July 1, 2009</i>	New section
Sec. 37	<i>July 1, 2009</i>	New section
Sec. 38	<i>July 1, 2009</i>	New section
Sec. 39	<i>July 1, 2010</i>	New section
Sec. 40	<i>July 1, 2009</i>	New section
Sec. 41	<i>July 1, 2009</i>	New section
Sec. 42	<i>January 1, 2010</i>	Repealer section

Statement of Purpose:

To expand the availability and affordability of health insurance benefits to all Connecticut residents.

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

Co-Sponsors: REP. SCHOFIELD, 16th Dist.; REP. O'CONNOR, 35th Dist.
REP. MIOLI, 136th Dist.; SEN. CRISCO, 17th Dist.
SEN. WITKOS, 8th Dist.; REP. FRITZ, 90th Dist.
REP. BERGER, 73rd Dist.

H.B. 5172