



General Assembly

Substitute Bill No. 6152

January Session, 2009

* HB06152APP 050609 *

AN ACT ESTABLISHING A CATASTROPHIC MEDICAL EXPENSES POOL.

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

1 Section 1. (NEW) (*Effective July 1, 2009*) As used in sections 1 to 8,
2 inclusive, of this act:

3 (1) "Commission" means the Catastrophic Medical Expenses
4 Commission established pursuant to section 3 of this act.

5 (2) "Family income" means all net income from all sources received
6 by a family in a calendar year, excluding payments or reimbursements
7 received from the pool.

8 (3) "Pool" means the catastrophic medical expenses pool established
9 pursuant to section 2 of this act.

10 Sec. 2. (NEW) (*Effective July 1, 2009*) (a) There is established a
11 catastrophic medical expenses pool to provide payment or
12 reimbursement for medical and related expenses beginning January 1,
13 2010, that exceed the family income levels set forth in section 6 of this
14 act. The Office of the Healthcare Advocate shall administer the pool in
15 accordance with the provisions of sections 1 to 8, inclusive, of this act
16 and with the advice of the Catastrophic Medical Expenses
17 Commission.

18 (b) Services, equipment and other expenses eligible to be considered
19 for payment or reimbursement from the pool, subject to the limitations
20 and exclusions set forth in sections 5 and 6 of this act, include, but are
21 not limited to: (1) Durable medical equipment, hearing aids, medical or
22 surgical supplies, therapy services and prostheses or orthotics that are
23 covered benefits but which were denied in whole or in part because
24 policy or plan limitations have been reached; (2) health insurance (A)
25 premiums, (B) copayments, (C) deductibles, (D) coinsurance, and (E)
26 other out-of-pocket expenses paid by an applicant for a covered
27 benefit; and (3) other items determined by the commission or persons
28 designated by the commission pursuant to subdivision (14) of
29 subsection (a) of section 4 of this act to be directly related to the
30 medical condition of the applicant and necessary to maintain the
31 health and independence of the applicant or permit such applicant to
32 continue to remain at home.

33 (c) The commission shall make publicly available a list of medical
34 and related expenses that are eligible to be considered for payment or
35 reimbursement from the pool. The commission shall update such list at
36 least annually.

37 (d) Nothing in sections 1 to 8, inclusive, of this act shall be construed
38 to require the Office of the Healthcare Advocate or the commission to
39 make any payment or reimbursement of medical or related expenses to
40 an applicant.

41 Sec. 3. (NEW) (*Effective July 1, 2009*) (a) There is established a
42 Catastrophic Medical Expenses Commission within the Office of the
43 Healthcare Advocate. The commission shall consist of the Healthcare
44 Advocate, the Commissioners of Social Services and Public Health, the
45 Insurance Commissioner and the Comptroller, or their designees, and
46 ten additional members as follows:

47 (1) Two appointed by the speaker of the House of Representatives,
48 one of whom shall be a member of the joint standing committee of the
49 General Assembly having cognizance of matters relating to insurance;

50 (2) Two appointed by the president pro tempore of the Senate, one
51 of whom shall be a member of the joint standing committee of the
52 General Assembly having cognizance of matters relating to insurance;

53 (3) One appointed by the minority leader of the House of
54 Representatives, upon the recommendation of the president and chief
55 executive officer of the Connecticut Business and Industry Association
56 and who shall represent employers that are self-insured;

57 (4) One appointed by the minority leader of the Senate, who shall
58 represent the health insurance industry;

59 (5) Two appointed by the Attorney General, who shall be licensed
60 health care providers who currently provide health care services to
61 residents of the state; and

62 (6) Two appointed by the Governor, one of whom shall be a senior
63 manager or human resources director of a labor union that offers a
64 Taft-Hartley plan.

65 (b) The members appointed under subdivisions (1) to (6), inclusive,
66 of subsection (a) of this section shall serve for terms of five years,
67 except that the initial two members appointed by the Governor shall
68 serve for terms of three and four years, respectively. Any vacancy shall
69 be filled by the appointing authority. Members may be reappointed to
70 serve consecutive terms. Members shall serve without compensation
71 for their services but shall be reimbursed for their expenses.

72 (c) Any member appointed under subdivisions (1) to (6), inclusive,
73 of subsection (a) of this section may be removed for cause, after a
74 public hearing, by the official who appointed such member and may
75 be suspended by such official pending the completion of such hearing.

76 (d) The members shall elect a chairperson and a secretary of the
77 commission, neither of whom shall be a member of the General
78 Assembly. The commission shall, by rule, determine the term of office
79 of the chairperson and the secretary.

80 (e) Eight members of the commission shall constitute a quorum at
81 any meeting. A vacancy in the membership of the commission shall
82 not impair the right of a quorum to exercise all the powers and
83 perform all the duties of the commission.

84 (f) The members of the commission shall be appointed not later than
85 November 1, 2009, and the committee shall organize as soon as may be
86 practicable after such appointment.

87 Sec. 4. (NEW) (*Effective July 1, 2009*) (a) The Catastrophic Medical
88 Expenses Commission shall have the following powers and duties:

89 (1) To develop an application and establish procedures for applying
90 to the Office of the Healthcare Advocate for payment or
91 reimbursement of medical and related expenses from the pool;

92 (2) To establish rules and procedures for determining the eligibility
93 of applicants and the eligibility of requests for payment or
94 reimbursement of medical and related expenses from the pool,
95 including, but not limited to, (A) the documentation or information
96 required from the applicant to substantiate the eligibility of the
97 applicant or the request for payment or reimbursement, (B) methods to
98 verify family income, (C) limits, if any, on the number of times an
99 applicant may apply in a calendar year, (D) limits, if any, on the dollar
100 amount that may be paid to an applicant in a calendar year, (E)
101 whether an application submitted by a member of an applicant's
102 family or payment made to such family member is aggregated in any
103 such limits imposed on an applicant, (F) methods to verify previous
104 payments to an applicant, if necessary, and (G) methods to verify other
105 available sources of payment have been exhausted;

106 (3) To establish an approval process, including, but not limited to,
107 any criteria to be used to prioritize payments or reimbursements made
108 from the pool, except that in the event the moneys in the account
109 established under section 8 of this act are inadequate to cover all the
110 requests made for payment or reimbursement, any applicant who is
111 transitioning to medically needy status under the Medicaid program

112 and who otherwise meets the criteria under sections 5 and 6 of this act
113 shall be given preference for payment of reimbursement from the pool;

114 (4) To establish procedures for an applicant notification process,
115 including, but not limited to, the time frames for the Office of the
116 Healthcare Advocate to approve or deny an application or request for
117 payment or reimbursement and for applicants to submit additional
118 information if a denial was based on incomplete information;

119 (5) To establish a list of services, programs, treatments, products
120 and expenses excluded under subsection (c) of section 6 of this act;

121 (6) To develop payment rates in accordance with subdivision (1) of
122 subsection (a) of section 7 of this act;

123 (7) To establish criteria for and procedures to (A) preapprove
124 payments pursuant to section 7 of this act, and (B) make payments or
125 reimbursements, including, but not limited to, the method of payment
126 and time frame for the Office of the Healthcare Advocate to process
127 such payment;

128 (8) To establish procedures for repayment by an applicant to the
129 pool where such applicant, after receiving payment from the pool,
130 recovers the costs of medical and related expenses pursuant to a
131 settlement or judgment in a legal action;

132 (9) To establish procedures by which moneys in the account
133 established under section 8 of this act shall be expended, taking into
134 consideration payments that have been preapproved pursuant to
135 section 7 of this act and administrative costs to be paid as set forth in
136 section 8 of this act;

137 (10) To develop an asset test to be used if pool funds appear to be
138 inadequate to cover requests for payment or reimbursement;

139 (11) To make publicly available and update at least annually a list of
140 (A) medical and related expenses that are eligible to be considered for
141 payment or reimbursement from the pool, subject to the limitations

142 and exclusions under sections 5 and 6 of this act, and (B) exclusions
143 established pursuant to this subsection;

144 (12) To establish and maintain a record, electronic or otherwise, of
145 each applicant. Such records shall be maintained in a secure location,
146 shall be confidential and shall not be disclosed except as required by
147 law and to members of the commission, provided such members
148 agree, in writing, to keep such records confidential;

149 (13) To disseminate information to the public concerning the pool,
150 including, but not limited to, the benefits available from the pool,
151 procedures to apply and contact information for the Office of the
152 Healthcare Advocate;

153 (14) To enter into contracts, within the moneys available in the pool,
154 to carry out the provisions of sections 1 to 8, inclusive, of this act,
155 including, but not limited to, entering into contracts with licensed
156 physicians and clinicians to assist the commission in performing its
157 duties and to designate persons who have the appropriate expertise to
158 assist the commission in performing its duties;

159 (15) To accept grants of private or federal funds to the pool, and to
160 accept gifts, donations or bequests including donations of services; and

161 (16) To take any other action necessary to carry out the provisions of
162 sections 1 to 8, inclusive, of this act.

163 (b) The commission shall adopt regulations, in accordance with
164 chapter 54 of the general statutes, to implement the provisions of
165 subdivisions (1) to (10), inclusive, of subsection (a) of this section. The
166 commission may adopt regulations, in accordance with chapter 54 of
167 the general statutes, to implement any other provision of sections 1 to
168 8, inclusive, of this act.

169 Sec. 5. (NEW) (*Effective July 1, 2009*) To be eligible to apply for
170 payment or reimbursement from the pool, a person shall:

171 (1) Be covered by:

172 (A) An individual or group health insurance policy providing
173 coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)
174 of section 38a-469 of the general statutes;

175 (B) A self-insured comprehensive group medical or health care
176 benefit plan. The Catastrophic Medical Expenses Commission shall
177 determine what constitutes a comprehensive plan for the purposes of
178 this subparagraph;

179 (C) The Municipal Employee Health Insurance Plan set forth in
180 section 5-259 of the general statutes;

181 (D) The Charter Oak Health Plan set forth in section 17b-311 of the
182 general statutes;

183 (E) A comprehensive individual or group health care plan set forth
184 in section 38a-552 or 38a-554 of the general statutes;

185 (F) Medicare and a Medicare supplement insurance policy; or

186 (G) A high deductible plan, as defined in Section 220(c)(2) or Section
187 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent
188 corresponding internal revenue code of the United States, as amended
189 from time to time, used to establish a "medical savings account" or
190 "Archer MSA" pursuant to Section 220 of said Internal Revenue Code
191 or a "health savings account" pursuant to Section 223 of said Internal
192 Revenue Code, provided such medical savings account or health
193 savings account has been exhausted and subsequent medical and
194 related expenses exceed the limits established in section 6 of this act.

195 (2) Not be eligible for benefits under Medicaid, HUSKY Plan or
196 state-administered general assistance on the date the medical or
197 related expenses for which reimbursement is requested from the pool
198 were incurred;

199 (3) Be a resident of this state;

200 (4) Be a citizen or resident alien of the United States; and

201 (5) Have exhausted other sources of payment for the requested
202 payment or reimbursement.

203 Sec. 6. (NEW) (*Effective July 1, 2009*) (a) The amount of payment or
204 reimbursement in a calendar year shall be limited to:

205 (1) For family income that is less than or equal to two hundred per
206 cent of the federal poverty level, medical and related expenses paid by
207 an applicant in a calendar year that are in excess of eight per cent of
208 such family income;

209 (2) For family income that is greater than two hundred per cent but
210 less than or equal to three hundred per cent of the federal poverty
211 level, medical and related expenses paid by an applicant in a calendar
212 year that are in excess of nine per cent of such family income;

213 (3) For family income that is greater than three hundred per cent but
214 less than or equal to four hundred per cent of the federal poverty level,
215 medical and related expenses paid by an applicant in a calendar year
216 that are in excess of ten per cent of such family income;

217 (4) For family income that is greater than four hundred per cent but
218 less than or equal to five hundred per cent of the federal poverty level,
219 medical and related expenses paid by an applicant in a calendar year
220 that are in excess of twelve and one-half per cent of such family
221 income;

222 (5) For family income that is greater than five hundred per cent but
223 less than or equal to one thousand per cent of the federal poverty level,
224 medical and related expenses paid by an applicant in a calendar year
225 that are in excess of fifteen per cent of such family income; and

226 (6) For family income that is greater than one thousand per cent but
227 less than or equal to one thousand three hundred per cent of the
228 federal poverty level, medical and related expenses paid by an
229 applicant in a calendar year that are in excess of twenty-five per cent of
230 such family income.

231 (b) An applicant with a family income that is greater than one
232 thousand three hundred per cent of the federal poverty level shall not
233 be eligible for payment or reimbursement from the pool.

234 (c) The following expenses shall be excluded from payment or
235 reimbursement from the pool:

236 (1) Costs for services that would normally be provided by or
237 available through (A) the birth-to-three program set forth in section
238 17a-248 of the general statutes, (B) the Department of Developmental
239 Services, (C) the Department of Mental Health and Addiction Services,
240 (D) the Department of Public Health, or (E) an individualized family
241 service plan pursuant to section 17a-248e of the general statutes, an
242 individualized education program pursuant to section 10-76d of the
243 general statutes or any other individualized service plan. Such costs
244 may be eligible for payment or reimbursement from the pool at the
245 discretion of the Office of the Healthcare Advocate if the applicant was
246 ineligible for such services due to the financial eligibility criteria of a
247 program or agency or due to a limit on the number of clients served by
248 such program or agency;

249 (2) Costs for long-term care provided in a nursing home facility,
250 rehabilitation facility or at home that exceeds or is expected to exceed
251 six months;

252 (3) Premiums, copayments, deductibles, coinsurance and other out-
253 of-pocket expenses paid by an applicant for a long-term care policy;

254 (4) Items that were denied because the insured or enrollee failed to
255 comply with the terms of the insurer such as network or prior
256 authorization requirements;

257 (5) Items that are not cost-effective or appropriate for the applicant's
258 medical condition, as determined by the commission or persons
259 designated by the commission pursuant to subdivision (14) of
260 subsection (a) of section 4 of this act. Such determination may be made
261 separately from any decision made by an insurer, health care center or

262 utilization review company concerning such items. If said commission
263 disagrees with such decision made by an insurer, health care center or
264 utilization review company, said commission may be a party to an
265 appeal filed by the applicant with such insurer, health care center or
266 utilization review company;

267 (6) Infertility diagnosis and treatments;

268 (7) Massage services, natureopathy and other alternative medicine
269 treatments or services;

270 (8) Dental braces, dentures, cosmetic dental procedures and routine
271 dental services including, but not limited to, fillings, cleanings and
272 other prophylaxis measures;

273 (9) Eyeglass frames costing over fifty dollars, adjusted annually by
274 the increase in the consumer price index for urban consumers during
275 the preceding twelve-month period according to the United States
276 Bureau of Labor Statistics data;

277 (10) Pharmaceutical products, biological products or any substance
278 that may be lawfully sold over the counter without a prescription
279 under the federal Food, Drug and Cosmetics Act, 21 USC 301 et seq., as
280 amended from time to time;

281 (11) Vitamins or food supplements, unless prescribed for a
282 diagnosed medical condition;

283 (12) Cosmetics;

284 (13) Services, treatments or products that are more expensive than
285 equally effective alternatives, as determined by the commission or
286 persons designated by the commission pursuant to subdivision (14) of
287 subsection (a) of section 4 of this act; and

288 (14) Other programs, services or expenses the commission may
289 choose to exclude pursuant to regulations adopted in accordance with
290 chapter 54 of the general statutes.

291 (d) Payment or reimbursement from the pool for wheelchairs and
292 hearing aids shall be limited to: (1) Once every biennium for persons
293 under the age of eighteen years; and (2) once every ten years for
294 persons over the age of eighteen years.

295 Sec. 7. (NEW) (*Effective July 1, 2009*) (a) If payment of a medical or
296 related expense is preapproved by the Office of the Healthcare
297 Advocate:

298 (1) Said office shall remit such payment to the insured's or enrollee's
299 health care provider at the Medicare allowable rate for such medical or
300 related expense. If there is no comparable Medicare allowable rate,
301 said office, with the advice of the Catastrophic Medical Expenses
302 Commission, shall develop a rate based on current Medicaid and
303 insurer rates, or on rates negotiated by the Healthcare Advocate where
304 no current Medicaid or insurer rate exists.

305 (2) Said office may preapprove a payment in accordance with the
306 rules and procedures established by the commission, provided (A) the
307 insured's or enrollee's health care or services provider has agreed, in
308 writing, to accept such payment as payment in full on behalf of such
309 insured or enrollee for such medical or related expense, (B) the insurer,
310 health care center, self-insured employer, insured or enrollee, as
311 applicable, provides any documentation or information required by
312 said office to determine the eligibility of the applicant or the request
313 for payment, and any previous payments made to such applicant from
314 the pool, and (C) there are sufficient funds in the pool.

315 (3) Said office may preapprove payment of a related expense not
316 typically considered medical if the commission or persons designated
317 by the commission pursuant to subdivision (14) of subsection (a) of
318 section 4 of this act deem such related expense necessary to
319 maintaining the independence of the applicant or the ability of such
320 applicant to remain at home.

321 (b) If reimbursement of a medical or related expense is approved by
322 the Office of the Healthcare Advocate:

323 (1) The applicant shall submit the bill to said office with proof of
324 payment.

325 (2) Said office may pay all or part of such bill, based on (A) the rate
326 said office would have paid pursuant to subdivision (1) of subsection
327 (a) of this section, (B) the appropriateness and necessity of the
328 particular medical or related expense, and (C) the availability of funds
329 in the pool.

330 (c) Notwithstanding the provisions of chapter 319v of the general
331 statutes, any payment or reimbursement to an applicant from the pool
332 shall not be counted as income or assets for the purposes of
333 determining eligibility for medical assistance.

334 Sec. 8. (NEW) (*Effective July 1, 2009*) (a) There is established an
335 account to be known as the "catastrophic medical expenses account",
336 which shall be a separate, nonlapsing account within the Insurance
337 Fund established under section 38a-52a of the general statutes. The
338 account shall contain any moneys required by law to be deposited in
339 the account. Moneys in the account shall be expended by the Office of
340 the Healthcare Advocate for the purposes of paying or reimbursing
341 medical and related expenses, paying administrative costs and paying
342 licensed physicians and clinicians contracted by the Catastrophic
343 Medical Expenses Commission, in accordance with sections 1 to 8,
344 inclusive, of this act.

345 (b) (1) Each insurer or health care center that delivers, issues for
346 delivery, renews, amends or continues in this state individual or group
347 health insurance policies or plans and third party administrator that
348 provides services in this state under an administrative services only
349 contract shall collect one dollar per life covered on January first of each
350 year and shall remit such moneys to the Office of the Healthcare
351 Advocate not later than thirty days after collection. All such moneys
352 shall be deposited in the account set forth in subsection (a) of this
353 section.

354 (2) The Department of Revenue Services shall collect one dollar per

355 life covered on January first of each year under the Charter Oak Health
356 Plan set forth in section 17b-311 of the general statutes and shall remit
357 such moneys to the Office of the Healthcare Advocate not later than
358 thirty days after collection. All such moneys shall be deposited in the
359 account set forth in subsection (a) of this section.

360 (c) The Office of the Healthcare Advocate shall pay all costs that do
361 not exceed five per cent of the total amount transferred into the pool in
362 a calendar year and are related to the management of the pool,
363 including, but not limited to, costs for staff to manage the program and
364 coordinate the work assigned by the commission, materials
365 development, printing, postage and telephone expenses. Any such
366 expenses that exceed five per cent of the total amount transferred into
367 the pool in a calendar year shall require approval for payment by the
368 commission.

369 (d) The Commissioner of Social Services shall seek any federal
370 matching funds available for the pool.

371 (e) When the moneys in the account have been exhausted, no
372 payments or reimbursements shall be made until moneys have been
373 deposited in the succeeding calendar year pursuant to subsection (b) of
374 this section.

375 Sec. 9. Section 38a-1041 of the general statutes is repealed and the
376 following is substituted in lieu thereof (*Effective July 1, 2009*):

377 (a) There is established an Office of the Healthcare Advocate which
378 shall be within the Insurance Department for administrative purposes
379 only.

380 (b) The Office of the Healthcare Advocate may:

381 (1) Assist health insurance consumers with managed care plan
382 selection by providing information, referral and assistance to
383 individuals about means of obtaining health insurance coverage and
384 services;

385 (2) Assist health insurance consumers to understand their rights and
386 responsibilities under managed care plans;

387 (3) Provide information to the public, agencies, legislators and
388 others regarding problems and concerns of health insurance
389 consumers and make recommendations for resolving those problems
390 and concerns;

391 (4) Assist consumers with the filing of complaints and appeals,
392 including filing appeals with a managed care organization's internal
393 appeal or grievance process and the external appeal process
394 established under section 38a-478n;

395 (5) Analyze and monitor the development and implementation of
396 federal, state and local laws, regulations and policies relating to health
397 insurance consumers and recommend changes it deems necessary;

398 (6) Facilitate public comment on laws, regulations and policies,
399 including policies and actions of health insurers;

400 (7) Ensure that health insurance consumers have timely access to the
401 services provided by the office;

402 (8) Review the health insurance records of a consumer who has
403 provided written consent for such review;

404 (9) Create and make available to employers a notice, suitable for
405 posting in the workplace, concerning the services that the Healthcare
406 Advocate provides;

407 (10) Establish a toll-free number, or any other free calling option, to
408 allow customer access to the services provided by the Healthcare
409 Advocate;

410 (11) Pursue administrative remedies on behalf of and with the
411 consent of any health insurance consumers;

412 (12) Adopt regulations, pursuant to chapter 54, to carry out the

413 provisions of sections 38a-1040 to 38a-1050, inclusive; and

414 (13) Take any other actions necessary to fulfill the purposes of
415 sections 38a-1040 to 38a-1050, inclusive.

416 (c) The Office of the Healthcare Advocate shall make a referral to
417 the Insurance Commissioner if the Healthcare Advocate finds that a
418 preferred provider network may have engaged in a pattern or practice
419 that may be in violation of sections 38a-226 to 38a-226d, inclusive, 38a-
420 479aa to 38a-479gg, inclusive, or 38a-815 to 38a-819, inclusive.

421 (d) The Healthcare Advocate and the Insurance Commissioner shall
422 jointly compile a list of complaints received against managed care
423 organizations and preferred provider networks and the commissioner
424 shall maintain the list, except the names of complainants shall not be
425 disclosed if such disclosure would violate the provisions of section 4-
426 61dd or 38a-1045.

427 (e) On or before October 1, 2005, the Managed Care Ombudsman, in
428 consultation with the Community Mental Health Strategy Board,
429 established under section 17a-485b, shall establish a process to provide
430 ongoing communication among mental health care providers, patients,
431 state-wide and regional business organizations, managed care
432 companies and other health insurers to assure: (1) Best practices in
433 mental health treatment and recovery; (2) compliance with the
434 provisions of sections 38a-476a, 38a-476b, 38a-488a and 38a-489; and (3)
435 the relative costs and benefits of providing effective mental health care
436 coverage to employees and their families. On or before January 1, 2006,
437 and annually thereafter, the Healthcare Advocate shall report, in
438 accordance with the provisions of section 11-4a, on the implementation
439 of this subsection to the joint standing committees of the General
440 Assembly having cognizance of matters relating to public health and
441 insurance.

442 (f) On or before October 1, 2008, the Office of the Healthcare
443 Advocate shall, within available appropriations, establish and
444 maintain a healthcare consumer information web site on the Internet

445 for use by the public in obtaining healthcare information, including but
 446 not limited to: (1) The availability of wellness programs in various
 447 regions of Connecticut, such as disease prevention and health
 448 promotion programs; (2) quality and experience data from hospitals
 449 licensed in this state; and (3) a link to the consumer report card
 450 developed and distributed by the Insurance Commissioner pursuant to
 451 section 38a-478l.

452 (g) The Office of the Healthcare Advocate shall administer the
 453 catastrophic medical expenses pool established under section 2 of this
 454 act, and shall make payments and reimbursements in accordance with
 455 sections 1 to 8, inclusive, of this act. Said office may adopt regulations,
 456 in accordance with chapter 54, to implement the provisions of sections
 457 1 to 8, inclusive, of this act.

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>July 1, 2009</i>	New section
Sec. 5	<i>July 1, 2009</i>	New section
Sec. 6	<i>July 1, 2009</i>	New section
Sec. 7	<i>July 1, 2009</i>	New section
Sec. 8	<i>July 1, 2009</i>	New section
Sec. 9	<i>July 1, 2009</i>	38a-1041

INS *Joint Favorable Subst.*

APP *Joint Favorable*