House of Representatives

General Assembly

File No. 620

January Session, 2011

Substitute House Bill No. 6323

House of Representatives, April 26, 2011

The Committee on Finance, Revenue and Bonding reported through REP. WIDLITZ of the 98th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT MAKING CONFORMING CHANGES TO THE INSURANCE STATUTES PURSUANT TO THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT, AND ESTABLISHING A STATE HEALTH PARTNERSHIP PROGRAM.

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

Section 1. Section 38a-497 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

[Every**]** Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state shall provide that coverage of a child shall terminate no earlier than the policy anniversary date on or after whichever of the following occurs first, the date on which the child: **[**Marries; ceases to be a resident of the state; becomes**]** Becomes covered under a group health plan through the dependent's own employment; or attains the age of twenty-six. **[**The residency

requirement shall not apply to dependent children under nineteen years of age or full-time students attending an accredited institution of higher education.**]** Each such policy shall cover a stepchild on the same basis as a biological child.

Sec. 2. Subsections (a) and (b) of section 38a-554 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The plan shall be one under which the individuals eligible to be covered include: (1) Each eligible employee; (2) the spouse of each eligible employee, who shall be considered a dependent for the purposes of this section; and (3) **[**unmarried**]** children who are under twenty-six years of age. Each plan shall cover a stepchild on the same basis as a biological child.

(b) The plan shall provide the option to continue coverage under each of the following circumstances until the individual is eligible for other group insurance, except as provided in subdivisions (3) and (4) of this subsection:

(1) Notwithstanding any provision of this section, upon layoff, reduction of hours, leave of absence or termination of employment, other than as a result of death of the employee or as a result of such employee's "gross misconduct" as that term is used in 29 USC 1163(2), continuation of coverage for such employee and such employee's covered dependents for a period of thirty months after the date of such layoff, reduction of hours, leave of absence or termination of employment, except that if such reduction of hours, leave of absence or termination of employment results from an employee's eligibility to receive Social Security income, continuation of coverage for such employee and such employee's covered dependents until midnight of the day preceding such person's eligibility for benefits under Title XVIII of the Social Security Act;

(2) Upon the death of the employee, continuation of coverage for the covered dependents of such employee for the periods set forth for such

event under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended from time to time;

(3) Regardless of the employee's or dependent's eligibility for other group insurance, during an employee's absence due to illness or injury, continuation of coverage for such employee and such employee's covered dependents during continuance of such illness or injury or for up to twelve months from the beginning of such absence;

(4) Regardless of an individual's eligibility for other group insurance, upon termination of the group plan, coverage for covered individuals who were totally disabled on the date of termination shall be continued without premium payment during the continuance of such disability for a period of twelve calendar months following the calendar month in which the plan was terminated, provided claim is submitted for coverage within one year of the termination of the plan;

(5) The coverage of any covered individual shall terminate: (A) As to a child, the plan shall provide the option for said child to continue coverage for the longer of the following periods: (i) At the end of the month following the month in which the child: **[**Marries; ceases to be a resident of the state; becomes**]** Becomes covered under a group health plan through the dependent's own employment; or attains the age of twenty-six. **[**The residency requirement shall not apply to dependent children under nineteen years of age or full-time students attending an accredited institution of higher education.**]** If on the date specified for termination of coverage on a child, the child is **[**unmarried and**]** incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the employee for support and maintenance, the coverage on such child shall continue while the plan remains in force and the child remains in such condition, provided proof of such handicap is received by the carrier within thirty-one days of the date on which the child's coverage would have terminated in the absence of such incapacity. The carrier may require subsequent proof of the child's continued incapacity and

dependency but not more often than once a year thereafter, or (ii) for the periods set forth for such child under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended from time to time; (B) as to the employee's spouse, at the end of the month following the month in which a divorce, court-ordered annulment or legal separation is obtained, whichever is earlier, except that the plan shall provide the option for said spouse to continue coverage for the periods set forth for such events under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended from time to time; and (C) as to the employee or dependent who is sixty-five years of age or older, as of midnight of the day preceding such person's eligibility for benefits under Title XVIII of the federal Social Security Act;

(6) As to any other event listed as a "qualifying event" in 29 USC 1163, as amended from time to time, continuation of coverage for such periods set forth for such event in 29 USC 1162, as amended from time to time, provided such plan may require the individual whose coverage is to be continued to pay up to the percentage of the applicable premium as specified for such event in 29 USC 1162, as amended from time to time.

Any continuation of coverage required by this section except subdivision (4) or (6) of this subsection may be subject to the requirement, on the part of the individual whose coverage is to be continued, that such individual contribute that portion of the premium the individual would have been required to contribute had the employee remained an active covered employee, except that the individual may be required to pay up to one hundred two per cent of the entire premium at the group rate if coverage is continued in accordance with subdivision (1), (2) or (5) of this subsection. The employer shall not be legally obligated by sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, to pay such premium if not paid timely by the employee.

Sec. 3. Subsection (a) of section 5-259 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Comptroller, with the approval of the Attorney General and of the Insurance Commissioner, shall arrange and procure a group hospitalization and medical and surgical insurance plan or plans for (1) state employees, (2) members of the General Assembly who elect coverage under such plan or plans, (3) participants in an alternate retirement program who meet the service requirements of section 5-162 or subsection (a) of section 5-166, (4) anyone receiving benefits under section 5-144 or from any state-sponsored retirement system, except the teachers' retirement system and the municipal employees retirement system, (5) judges of probate and Probate Court employees, (6) the surviving spouse, and any dependent children until they reach the age of **[**eighteen**]** twenty-six, of a state police officer, a member of an organized local police department, a firefighter or a constable who performs criminal law enforcement duties who dies before, on or after June 26, 2003, as the result of injuries received while acting within the scope of such officer's or firefighter's or constable's employment and not as the result of illness or natural causes, and whose surviving spouse and dependent children are not otherwise eligible for a group hospitalization and medical and surgical insurance plan, (7) employees of the Capital City Economic Development Authority established by section 32-601, and (8) the surviving spouse and dependent children of any employee of a municipality who dies on or after October 1, 2000, as the result of injuries received while acting within the scope of such employee's employment and not as the result of illness or natural causes, and whose surviving spouse and dependent children are not otherwise eligible for a group hospitalization and medical and surgical insurance plan. For purposes of this subdivision, "employee" means any regular employee or elective officer receiving pay from a municipality, "municipality" means any town, city, borough, school district, taxing district, fire district, district department of health, probate district, housing authority, regional work force development board established under section 31-3k, flood commission or authority

established by special act or regional planning agency. For purposes of subdivision (6) of this subsection, "firefighter" means any person who is regularly employed and paid by any municipality for the purpose of performing firefighting duties for a municipality on average of not less than thirty-five hours per week. The minimum benefits to be provided by such plan or plans shall be substantially equal in value to the benefits that each such employee or member of the General Assembly could secure in such plan or plans on an individual basis on the preceding first day of July. The state shall pay for each such employee and each member of the General Assembly covered by such plan or plans the portion of the premium charged for such member's or employee's individual coverage and seventy per cent of the additional cost of the form of coverage and such amount shall be credited to the total premiums owed by such employee or member of the General Assembly for the form of such member's or employee's coverage under such plan or plans. On and after January 1, 1989, the state shall pay for anyone receiving benefits from any such state-sponsored retirement system one hundred per cent of the portion of the premium charged for such member's or employee's individual coverage and one hundred per cent of any additional cost for the form of coverage. The balance of any premiums payable by an individual employee or by a member of the General Assembly for the form of coverage shall be deducted from the payroll by the State Comptroller. The total premiums payable shall be remitted by the Comptroller to the insurance company or companies or nonprofit organization or organizations providing the coverage. The amount of the state's contribution per employee for a health maintenance organization option shall be equal, in terms of dollars and cents, to the largest amount of the contribution per employee paid for any other option that is available to all eligible state employees included in the health benefits plan, but shall not be required to exceed the amount of the health maintenance organization premium.

Sec. 4. Subsection (f) of section 5-259 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(f) The Comptroller, with the approval of the Attorney General and of the Insurance Commissioner, shall arrange and procure a group hospitalization and medical and surgical insurance plan or plans for any person who adopts a child from the state foster care system, any person who has been a foster parent for the Department of Children and Families for six months or more, a parent in a permanent family residence for six months or more, and any dependent of such adoptive parent, foster parent or parent in a permanent family residence who elects coverage under such plan or plans. The Comptroller may also arrange for inclusion of such person and any such dependent in an existing group hospitalization and medical and surgical insurance plan offered by the state. Any adoptive parent, foster parent or a parent in a permanent family residence and any dependent who elects coverage shall pay one hundred per cent of the premium charged for such coverage directly to the insurer, provided such adoptive parent, foster parent or parent and all such dependents shall be included in such group hospitalization and medical and surgical insurance plan. A person and his dependents electing coverage pursuant to this subsection shall be eligible for such coverage until no longer an adoptive parent, a foster parent or a parent in a permanent family residence. An adoptive parent shall be eligible for such coverage until the adopted child reaches the age of **[**eighteen or, if the child has not completed a secondary education program, until such child reaches the age of twenty-one**]** twenty-six. As used in this section "dependent" means a spouse or natural or adopted child if such child is wholly or partially dependent for support upon the adoptive parent, foster parent or parent in a permanent family residence.

Sec. 5. Subsection (b) of section 38a-476 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) (1) No group health insurance plan or insurance arrangement shall impose a preexisting conditions provision that excludes coverage for (A) individuals eighteen years of age and younger, or (B) a period beyond twelve months following the insured's effective date of

coverage. Any preexisting conditions provision shall only relate to conditions, whether physical or mental, for which medical advice, diagnosis or care or treatment was recommended or received during the six months immediately preceding the effective date of coverage.

(2) No individual health insurance plan or insurance arrangement shall impose a preexisting conditions provision that excludes coverage for (A) individuals eighteen years of age and younger, or (B) a period beyond twelve months following the insured's effective date of coverage. Any preexisting conditions provision shall only relate to conditions, whether physical or mental, for which medical advice, diagnosis or care or treatment was recommended or received during the twelve months immediately preceding the effective date of coverage.

Sec. 6. Section 38a-553 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) All individual and all group comprehensive health care plans shall include minimum standard benefits as described in this **[**section**]** subsection.

[(a) Except as provided in subsections (b) and (c), minimum**]** (1) Minimum standard benefits shall be benefits, including coverage for catastrophic illness, **[**with a lifetime maximum of one million dollars per individual, for reasonable charges or, when applicable, the allowance agreed upon between a provider and a carrier for charges actually incurred,**]** for the following health care services, rendered to an individual covered by such plan for the diagnosis or treatment of nonoccupational disease or injury: **[**(1)**]** (A) Hospital services; **[**(2)**]** (B) professional services **[**which**]** that are rendered by a physician or, at **[**his**]** the physician's direction, by a registered nurse, other than services for mental or dental conditions; **[**(3)**]** (C) the diagnosis or treatment of mental conditions, in accordance with the minimum requirements established in section 38a-514; **[**(4)**]** (D) legend drugs requiring a prescription of a physician, advanced practice registered nurse or physician assistant; **[**(5)**]** (E) services of a skilled nursing

facility for not more than one hundred twenty days in a calendar year, provided such services commence within fourteen days following a confinement of at least three consecutive days in a hospital for the same condition; **[**(6)**]** (F) home health agency services, as defined by the commissioner, up to a maximum of one hundred eighty visits in a calendar year, provided such services commence **[**within**]** not later than seven days **[**following**]** after confinement in a hospital or skilled nursing facility of at least three consecutive days for the same condition, provided further, in the case of an individual diagnosed by a physician as terminally ill with a prognosis of six months or less to live, such home health agency services may commence irrespective of whether such covered person was so confined or, if such covered person was so confined, irrespective of such seven-day period, and the yearly benefit for medical social services, as hereinafter defined, shall not exceed two hundred dollars. "Medical social services" means services rendered, under the direction of a physician by a qualified social worker holding a master's degree from an accredited school of social work, including, but not limited to, **[**(A)**]** (i) assessment of the social, psychological and family problems related to or arising out of such covered person's illness and treatment; **[**(B)**]** (ii) appropriate action and utilization of community resources to assist in resolving such problems; **[**(C)**]** (iii) participation in the development of treatment for such covered person; **[**(7)**]** (G) use of radium or other radioactive materials; **[**(8)**]** (H) outpatient chemotherapy for the removal of tumors and treatment of leukemia, including outpatient chemotherapy; **[**(9)**]** (I) oxygen; **[**(10)**]** (J) anesthetics; **[**(11)**]** (K) nondental prosthesis and maxillo-facial prosthesis used to replace any anatomic structure lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis; **[**(12)**]** (L) rental of durable medical equipment which has no personal use in the absence of the condition for which prescribed; **[**(13)**]** (M) diagnostic x-rays and laboratory tests as defined by the commissioner; **[**(14)**]** (N) oral surgery for: **[**(A)**]** (i) Excision of partially or completely unerupted impacted teeth, or **[**(B)**]** (ii) excision of a tooth root without the extraction of the entire tooth; **[**(15)**]** (O) services of a licensed physical therapist,

rendered under the direction of a physician; **[**(16)**]** (P) transportation by a local professional ambulance to the nearest health care institution qualified to treat the illness or injury; **[**(17)**]** (Q) certain other services which are medically necessary in the treatment or diagnosis of an illness or injury as may be designated or approved by the Insurance Commissioner; and **[**(18)**]** (R) confinement in a facility established primarily for the treatment of alcoholism and licensed for such care by the state, or in a part of a hospital used primarily for such treatment, **[**shall be a covered expense**]** for a period of at least forty-five days within any calendar year.

(2) (A) No individual or group comprehensive health care plan shall include a lifetime limit on the dollar value of benefits for a covered individual, for covered benefits that are essential benefits as defined in the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time.

(B) Subparagraph (A) of this subdivision shall not prohibit the inclusion of a lifetime limit on specific covered benefits that are not essential health benefits, provided the lifetime limit for reasonable charges or, when applicable, the allowance agreed upon by a provider and a carrier for charges actually incurred for any specific covered benefit shall be not less than one million dollars per covered individual.

(3) No preexisting condition exclusion shall exclude coverage for any preexisting condition for individuals eighteen years of age and younger.

(b) Minimum standard benefits may include one or more of the following provisions:

(1) For policies issued or renewed prior to April 1, 1994, subject to the provisions of subdivision (3) of this subsection, such plan may require deductibles. The "low option deductible" shall be two hundred dollars per person, the "middle option deductible" shall be five hundred dollars per person, and the "high option deductible" shall be

seven hundred fifty dollars per person. The amount of the deductible may not be greater when a service is rendered on an outpatient basis than when that service is offered on an inpatient basis. Expenses incurred during the last three months of a calendar year and actually applied to an individual's deductible for that year shall be applied to that individual's deductible in the following calendar year. The two-hundred-dollar maximum, the five-hundred-dollar maximum and the seven-hundred-fifty-dollar maximum may be adjusted yearly to correspond with the change in the medical care component of the Consumer Price Index, as adjusted by the commissioner. The base year for such computation shall be the first full year of operation of such plan; **[**.**]**

(2) For policies issued or renewed prior to April 1, 1994, subject to the provisions of subdivision (3) of this subsection, such plan shall require a maximum copayment of twenty per cent for charges for all types of health care in excess of the deductible; **[**and fifty per cent for services listed in subdivision (3) of subsection (a) in excess of the deductible.**]**

(3) The sum of any deductible and copayments required in any calendar year may not exceed a maximum limit of one thousand dollars per covered individual, or two thousand dollars per covered family; provided, covered expenses incurred after the applicable maximum limit has been reached shall be paid at the rate of one hundred per cent. **[**, except that expenses incurred for treatment of mental and nervous conditions may be paid at the rate of fifty per cent as specified in subdivision (3) of subsection (a).**]** The one-thousand-dollar and two-thousand-dollar maximums shall be adjusted yearly to correspond with the change in the medical care component of the Consumer Price Index as adjusted by the commissioner; **[**.**]**

[(4) The plan shall limit benefits with respect to each pregnancy, other than a pregnancy involving complications of pregnancy, to a maximum of two hundred fifty dollars.

(5) The plan may limit lifetime benefits to a maximum of not less

than one million dollars per covered individual.**]**

[(6)**]** (4) No preexisting condition exclusion shall exclude coverage of any preexisting condition unless **[**: (A) The condition first manifested itself within the period of six months immediately prior to the effective date of coverage in such a manner as would cause a reasonably prudent person to seek diagnosis, care or treatment; (B) medical advice or treatment was recommended or received within the period of six months immediately prior to the effective date of coverage; or (C) the condition is pregnancy existing on**]** such exclusion only relates to conditions, whether physical or mental, for which medical advice, diagnosis or care or treatment was recommended or received during the six months immediately preceding the effective date of coverage. No policy shall exclude coverage for a loss due to preexisting conditions for a period greater than twelve months following the effective date of coverage. Any individual comprehensive health care plan issued as a result of conversion from group health insurance or from a self-insured group shall credit the time covered under such group health insurance toward any such exclusion.

(c) Plans providing minimum standard benefits need not provide benefits for the following: (1) Any charge for any care for any injury or disease either (A) arising out of and in the course of an employment subject to a workers' compensation or similar law or where such benefit is required to be provided under a workers' compensation policy to a sole proprietor, business partner or corporation officer who elects such coverage pursuant to the provisions of chapter 568, or (B) to the extent benefits are payable without regard to fault under a coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance; (2) any charge for treatment for cosmetic purposes other than surgery for the prompt repair of an accidental injury sustained while covered, provided cosmetic shall not mean replacement of any anatomic structure removed during treatment of tumors; (3) any charge for travel, other than transportation by local professional ambulance to the

nearest health care institution qualified to treat the illness or injury; (4) any charge for private room accommodations to the extent it is in excess of the institution's most common charge for a semiprivate room; (5) any charge by health care institutions to the extent that it is determined by the carrier that the charge exceeds the rates approved by the Office of Health Care Access division of the Department of Public Health; (6) any charge for services or articles to the extent that it exceeds the reasonable charge in the locality for the service; (7) any charge for services or articles **[**which**]** that are determined not to be medically necessary, except that this shall not apply to the fabrication or placement of the prosthesis as specified in subparagraph (K) of subdivision **[**(11)**]** (1) of subsection (a) of this section and subdivision (2) of this subsection; (8) any charge for services or articles the **[**provisions**]** provision of which is not within the scope of the license or certificate of the institution or individual rendering such services or articles; (9) any charge for services or articles furnished, paid for or reimbursed directly by or under any law of a government, except as otherwise provided in this subsection; (10) any charge for services or articles for custodial care or designed primarily to assist an individual in meeting **[**his**]** the individual's activities of daily living; (11) any charge for services **[**which**]** that would not have been made if no insurance existed or for which the covered individual is not legally obligated to pay; (12) any charge for eyeglasses, contact lenses or hearing aids or the fitting thereof; (13) any charge for dental care not specifically covered by sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive; and (14) any charge for services of a registered nurse who ordinarily resides in the covered individual's home, or who is a member of the covered individual's family or the family of the covered individual's spouse.

(d) and (e) Repealed by P.A. 84-499, S. 2.

(f) The minimum standard benefits of any individual or group comprehensive health care plan may be satisfied by catastrophic coverage offered in conjunction with basic hospital or medical-surgical plans on an expense incurred or service basis as approved by the

commissioner as providing at least equivalent benefits.

(g) Comprehensive health care plan carriers may offer alternative policy provisions and benefits, including cost containment features, consistent with the purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, provided such alternative provisions and benefits are approved by the Insurance Commissioner prior to their use. Cost containment features may include, but shall not be limited to, preferred provider provisions; utilization review of health care services, including review of the medical necessity of hospital and physician services; case management benefit alternatives; and other managed care provisions.

(h) Every comprehensive health care plan issued or renewed through the Health Reinsurance Association on or after April 1, 1994, shall be a managed care plan. Such managed care plans shall include one or more health care center plans or preferred provider network plans, as determined by the board of the association, with the approval of the commissioner. In the event that such managed care plans would not adequately serve enrollees in a particular area of the state, the board may offer to such enrollees a managed care product which contains alternative cost containment features, including, but not limited to, utilization review of health care services, review of the medical necessity of hospital and physician services and case management benefit alternatives.

(i) No comprehensive health care plan issued through the Health Reinsurance Association to a HIPAA eligible individual shall include any limitation or exclusion of benefits based on a preexisting condition.

(j) No comprehensive health care plan issued through the Health Reinsurance Association to a health care tax credit eligible individual shall include any limitation or exclusion of benefit based on a preexisting condition if such individual maintained creditable health insurance coverage for an aggregate period of three months as of the date on which the individual seeks to enroll in the Health Reinsurance

Association issued plan, not counting any period prior to a sixty-three-day break in coverage.

(k) (1) Each comprehensive health care plan issued through the Health Reinsurance Association shall provide coverage, under the terms and conditions of the plan, for the preexisting conditions of any group member or dependent who is newly insured under the plan on or after October 1, 2005, and was previously covered for such preexisting condition under the terms of the group member's or dependent's preceding qualifying coverage, provided the preceding qualifying coverage was continuous to a date less than one hundred twenty days prior to the effective date of the new coverage, exclusive of any applicable waiting period, except in the case of a newly insured group member whose preceding qualifying coverage was terminated due to an involuntary loss of employment, the preceding qualifying coverage must have been continuous to a date not more than one hundred fifty days prior to the effective date of the new coverage under the plan, exclusive of any applicable waiting period, provided the requirements of this subdivision shall only apply if the newly insured group member or dependent applies for such succeeding coverage not later than thirty days after the first day of the member's or dependent's initial eligibility.

(2) With respect to a group member or dependent who was newly insured under the plan on or after October 1, 2005, and was previously covered under qualifying coverage, but was not covered under such qualifying coverage for a preexisting condition, as defined under the newly issued comprehensive health care plan, such plan shall credit the time such group member or dependent was previously covered by qualifying coverage to the exclusion period of the preexisting condition provision, provided the preceding qualifying coverage was continuous to a date less than one hundred twenty days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan, except in the case of a newly insured group member whose preceding qualifying coverage was terminated due to an involuntary loss of employment, the preceding qualifying coverage

must have been continuous to a date not more than one hundred fifty days prior to the effective date of the new coverage, exclusive of any applicable waiting period, provided the requirements of this subdivision shall only apply if such newly insured group member or dependent applies for such succeeding coverage not later than thirty days after the first day of the member's or dependent's initial eligibility.

(3) As used in this subsection, "qualifying coverage" means coverage under (A) any group health insurance plan, group insurance arrangement or self-insured plan covering a group, (B) Medicare or Medicaid, or (C) an individual health insurance plan that provides benefits which are actuarially equivalent to or exceeding the benefits provided under a small employer health care plan, as defined in section 38a-564, as amended by this act, whether issued in this state or any other state, as determined by the Insurance Department.

Sec. 7. Subdivision (17) of section 38a-564 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(17) "Preexisting conditions provision" means a policy provision **[**which**]** that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage as to a condition **[**which**]** that, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinary prudent person to seek diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition. **[**or as to a condition which is pregnancy existing on the effective date of coverage.**]**

Sec. 8. Subsection (b) of section 38a-477b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) An insurer or health care center shall apply for approval of such

rescission, cancellation or limitation by submitting such written information to the Insurance Commissioner on an application in such form as the commissioner prescribes. Such insurer or health care center shall provide a copy of the application for such approval to the insured or the insured's representative. Not later than seven business days after receipt of the application for such approval, the insured or the insured's representative shall have an opportunity to review such application and respond and submit relevant information to the commissioner with respect to such application. Not later than fifteen business days after the submission of information by the insured or the insured's representative, the commissioner shall issue a written decision on such application. The commissioner **[**may**]** shall only approve: **[**such rescission, cancellation**]**

(1) Such rescission or limitation if the commissioner finds that **[**(1)**]** (A) the insured or such insured's representative submitted the written information **[**submitted**]** on or with the insurance application that was **[**false**]** fraudulent at the time such application was made, **[**and**]** (B) the insured or such insured's representative **[**knew or should have known of the falsity**]** intentionally misrepresented information therein **[**,**]** and such **[**submission**]** misrepresentation materially affects the risk or the hazard assumed by the insurer or health care center, or **[**(2)**]** (C) the information omitted from the insurance application was **[**knowingly**]** intentionally omitted by the insured or such insured's representative **[**, or the insured or such insured's representative should have known of such omission,**]** and such omission materially affects the risk or the hazard assumed by the insurer or health care center. Such decision shall be mailed to the insured, the insured's representative, if any, and the insurer or health care center; and

(2) Such cancellation in accordance with the provisions set forth in the Public Health Service Act, 42 USC 300gg et seq., as amended from time to time.

Sec. 9. Subparagraph (D) of subdivision (1) of section 38a-567 of the general statutes is repealed and the following is substituted in lieu

thereof (*Effective from passage*):

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

Sec. 10. Subsection (b) of section 38a-478*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(b) The consumer report card shall be known as the "Consumer Report Card on Health Insurance Carriers in Connecticut" and shall include (1) all health care centers licensed pursuant to chapter 698a, (2) the fifteen largest licensed health insurers that use provider networks and that are not included in subdivision (1) of this subsection, (3) the medical loss ratio of each such health care center or licensed health insurer, (4) the information required under subdivision (6) of subsection (a) of section 38a-478c, and (5) information concerning mental health services, as specified in subsection (c) of this section. The insurers selected pursuant to subdivision (2) of this subsection shall be selected on the basis of Connecticut direct written health premiums from such network plans. For the purposes of this section and sections 38a-477c, 38a-478c and 38a-478g, "medical loss ratio" **[**means the ratio of incurred claims to earned premiums for the prior calendar year for managed care plans issued in the state. Claims shall be limited to medical expenses for services and supplies provided to enrollees and shall not include expenses for stop loss coverage, reinsurance, enrollee educational programs or other cost containment programs or features**]** has the same meaning as, and shall be calculated in accordance with, the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and regulations adopted thereunder.

Sec. 11. (NEW) (*Effective from passage*) (a) For purposes of this section, "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and

regulations adopted thereunder.

(b) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation and health care center licensed to do business in the state shall comply with Sections 1251, 1252 and 1304 of the Affordable Care Act and the following Sections of the Public Health Service Act, as amended by the Affordable Care Act: (1) 2701 to 2709, inclusive, 42 USC 300gg et seq.; (2) 2711 to 2719A, inclusive, 42 USC 300gg-11 et seq.; and (3) 2794, 42 USC 300gg-94.

(c) This section shall apply, on and after the effective dates specified in the Affordable Care Act, to insurance companies, fraternal benefit societies, hospital service corporations, medical service corporations and health care centers licensed to do business in the state.

(d) The Insurance Commissioner may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 12. (NEW) (*Effective from passage*) Sections 12 to 20, inclusive, of this act shall be known as "The Connecticut Health Partnership Exchange Act".

Sec. 13. (NEW) (*Effective from passage*) As used in sections 12 to 20, inclusive, of this act:

(1) "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time;

(2) "Exchange" means the exchange established pursuant to section 14 of this act;

(3) (A) "Health benefit plan" means an insurance policy or contract offered, delivered, issued for delivery, renewed, amended or continued in this state to provide, deliver, pay for or reimburse any of the costs of health care services;

(B) "Health benefit plan" does not include:

(i) Coverage of the type specified in subdivisions (5), (6), (7), (8), (9), (14), (15) and (16) of section 38a-469 of the general statutes or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation insurance;

(v) Automobile medical payment insurance;

(vi) Credit insurance;

(vii) Coverage for on-site medical clinics;

(viii) Other insurance coverage similar to the coverages specified in subparagraphs (B)(ii) to (B)(vii), inclusive, of this subdivision that are specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, under which benefits for health care services are secondary or incidental to other insurance benefits;

(ix) (I) Limited scope dental or vision benefits, (II) benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof, or (III) other similar, limited benefits specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, provided any benefits specified in subparagraphs (B)(ix)(I) to (B)(ix)(III), inclusive, of this subdivision are provided under a separate insurance policy, certificate or contract and are not otherwise an integral part of a health benefit plan; or

(x) Coverage of the type specified in subdivisions (3) and (13) of section 38a-469 of the general statutes or other fixed indemnity insurance if (I) they are provided under a separate insurance policy, certificate or contract, (II) there is no coordination between the

provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and (III) the benefits are paid with respect to an event without regard to whether benefits were also provided under any group health plan maintained by the same plan sponsor;

(4) "Health care services" has the same meaning as provided in section 38a-478 of the general statutes;

(5) "Insurer" means any insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center authorized to transact insurance business in this state;

(6) "Person" has the same meaning as provided in section 38a-1 of the general statutes;

(7) "Small employer" has the same meaning as provided in section 38a-564 of the general statutes;

(8) "Qualified individual" has the same meaning as provided in Section 1312 of the Affordable Care Act;

(9) "Qualified employer" has the same meaning as provided in Section 1312 of the Affordable Care Act; and

(10) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in Section 1311(c) of the Affordable Care Act and section 18 of this act.

Sec. 14. (NEW) (*Effective from passage*) (a) There is hereby established and created a body politic and corporate, constituting a public instrumentality and political subdivision of the state of Connecticut established and created for the performance of an essential public and governmental function, to be known as the "Connecticut Health Partnership Exchange". The Connecticut Health Partnership Exchange is empowered to carry out the purposes of sections 12 to 20, inclusive,

of this act, which are hereby determined to be public purposes for which public funds may be expended. The exchange shall not be construed to be a department, institution or agency of this state.

(b) (1) The powers of the exchange shall be vested in and exercised by a board of directors, which shall consist of eleven members who shall be appointed on or before September 1, 2011, as follows:

(A) The Governor shall appoint two directors who shall each serve for a term of four years;

(B) The president pro tempore of the Senate shall appoint two directors who shall each serve for a term of three years;

(C) The speaker of the House of Representatives shall appoint two directors who shall each serve for a term of three years;

(D) The majority leader of the Senate shall appoint one director who shall serve for a term of three years;

(E) The majority leader of the House of Representatives shall appoint one director who shall serve for a term of three years;

(F) The minority leader of the Senate shall appoint one director who shall serve for a term of three years;

(G) The minority leader of the House of Representatives shall appoint one director who shall serve for a term of three years; and

(H) The Commissioner of Social Services, or the commissioner's designee, who shall serve as an ex-officio voting director.

Following the expiration of such initial terms, subsequent director terms shall be for four years, commencing on September first of the year of the appointment. Any director previously appointed to the exchange board of directors may be reappointed in accordance with this subsection.

(2) Each appointee, other than the Commissioner of Social Services,

shall have demonstrated expertise in at least two of the following areas: (A) Individual health insurance coverage; (B) small employer health insurance coverage; (C) health benefits plan administration; (D) health care finance; (E) public or private health care delivery system administration; or (F) health insurance plan purchase. When making an appointment, the appointing authority shall consider the expertise of the other directors to ensure the board's composition reflects a diversity of expertise and the cultural, ethnic and geographical communities of this state.

(3) (A) No appointee shall be employed by, a consultant to, a member of the board of directors of, affiliated with or otherwise a representative of (i) an insurer, (ii) an insurance producer or broker, (iii) a health care provider, or (iv) a health care facility or health or medical clinic while serving on the board or on the staff of the exchange. For purposes of this subdivision, "health care provider" means any person that is licensed in this state, or operates or owns a facility or institution in this state, to provide health care or health care professional services in this state, or an officer, employee or agent thereof acting in the course and scope of such officer's, employee's or agent's employment.

(B) No director or member of the staff of the exchange shall be a member, a member of the board or an employee of a trade association of (i) insurers, (ii) insurance producers or brokers, (iii) health care providers, or (iv) health care facilities or health or medical clinics while serving on the board or on the staff of the exchange.

(C) No director or member of the staff of the exchange shall be a health care provider unless such director or member of the staff receives no compensation for rendering services as a health care provider and does not have an ownership interest in a professional health care practice.

(c) As a condition of qualifying as a member of the board of directors of the exchange, each appointee shall, before entering upon such member's duties, take and subscribe the oath or affirmation

required under section 1 of article eleventh of the Constitution of the state. A record of each such oath shall be filed in the office of the Secretary of the State. Meetings of the board of directors shall be held at such times as shall be specified in the bylaws adopted by the board and at such other time or times as the chairperson deems necessary.

(d) The board of directors shall annually elect from among its members a chairperson and a vice-chairperson.

(e) Appointed directors may not designate a representative to perform in their absence their respective duties under sections 12 to 20, inclusive, of this act. Any appointed director who fails to attend three consecutive meetings of the board or who fails to attend fifty per cent of all meetings of the board held during any calendar year shall be deemed to have resigned from the board. Any appointed director may be removed by such director's appointing authority for misfeasance, malfeasance or wilful neglect of duty as determined in the sole discretion of the appointing authority. Any vacancy occurring other than by expiration of term shall be filled in the same manner as the original appointment for the balance of the unexpired term. Any director appointed to fill an unexpired term may be reappointed by the appointing authority for a full term and subsequent terms. If an appointing authority fails to make an initial appointment to the board or an appointment to fill a board vacancy within ninety days of the date of such vacancy, the appointed directors shall, by majority vote, make such appointment to the board.

(f) Six directors of the exchange shall constitute a quorum for the transaction of any business or the exercise of any power of the exchange. For the transaction of any business or the exercise of any power of the exchange, the exchange may act by a majority of the directors present at any meeting at which a quorum is in attendance. No vacancy in the membership of the board of directors shall impair the right of such directors to exercise all the rights and perform all the duties of the board. Any action taken by the board under the provisions of sections 12 to 20, inclusive, of this act may be authorized

by resolution approved by a majority of the directors present at any regular or special meeting, which resolution shall take effect immediately unless otherwise provided in the resolution.

(g) The directors shall receive no compensation for the performance of their official duties, except that each director shall be entitled to reimbursement for such director's actual and necessary expenses incurred during the performance of such director's official duties.

(h) The board may establish such committees, subcommittees or other entities it deems necessary to further the purposes of the exchange, including, but not limited to, a finance committee.

(i) Each director shall execute a surety bond in the penal sum of fifty thousand dollars, or, in lieu thereof, the chairperson of the board shall execute a blanket position bond covering each director, the executive director and the employees of the exchange, each surety bond to be conditioned upon the faithful performance of the duties of the office or offices covered, to be executed by a surety company authorized to transact business in this state as surety and to be approved by the Attorney General and filed in the office of the Secretary of the State. The cost of each such bond shall be paid by the exchange.

(j) The board shall adopt written procedures, in accordance with the provisions of section 1-121 of the general statutes, for: (1) Adopting an annual budget and plan of operations, including a requirement of board approval before the budget or plan may take effect; (2) hiring, dismissing, promoting and compensating employees of the exchange, including an affirmative action policy and a requirement of board approval before a position may be created or a vacancy filled; (3) acquiring real and personal property and personal services, including a requirement of board approval for any nonbudgeted expenditure in excess of five thousand dollars; (4) contracting for financial, legal and other professional services, including a requirement that the exchange solicit proposals at least once every three years for each such service which it uses; and (5) the use of surplus funds to the extent authorized under the provisions of sections 12 to 20, inclusive, of this act or any

other provision of the general statutes.

(k) The chairperson of the board, in consultation with the board, shall hire:

(1) An executive director of the exchange, who shall not be a member of the board and shall be exempt from the classified service. The executive director of the exchange shall serve at the pleasure of the board and receive such compensation as shall be fixed by the board; and

(2) A chief operations officer, a director of health plan contracting, a chief technology and information officer, a general counsel and other key executive positions as determined by the board, who shall not be members of the board and shall each be exempt from the classified service. The board shall set the salaries for each such position in amounts that are reasonably necessary to attract and retain individuals of superior qualifications. Such salaries shall be published by the board in the annual budget, which shall be posted on the Internet web site of the exchange. To determine the compensation for these positions, the board shall conduct, through the use of independent outside advisers, salary surveys of: (A) Other state and federal health insurance exchanges that are most comparable to the exchange; and (B) other relevant labor pools. The salaries established by the board under this subsection shall not exceed the highest comparable salary for a position of that type, as determined by such surveys. The Department of Administrative Services shall review the methodology used in such surveys.

(l) The executive director shall supervise the administrative affairs and technical activities of the exchange in accordance with the directives of the board. The executive director shall attend all board meetings and keep a record of the proceedings of the exchange and shall be custodian of all books, documents and papers filed with the exchange, the minute book or journal of the exchange and its official seal. The executive director may give certificates under the official seal of the exchange to the effect that such copies are true copies, and all

persons dealing with the exchange may rely upon such certificates.

(m) The exchange shall continue as long as it shall have legal authority to exist pursuant to the general statutes and until its existence is terminated by law. Upon the termination of the existence of the exchange, all its rights and properties shall pass to and be vested in the state of Connecticut.

(n) The exchange shall be subject to the Freedom of Information Act, as defined in section 1-200 of the general statutes, except that the following information shall not be subject to disclosure under section 1-210 of the general statutes: (1) The names and applications of individuals and employers seeking coverage through the exchange; (2) individuals' health information; and (3) information exchanged between the exchange and the (A) Departments of Social Services, Public Health and Revenue Services, (B) Insurance Department, (C) office of the Comptroller, or (D) any other state agency that is subject to confidentiality agreements under contracts entered into pursuant to subdivision (7) of section 15 of this act.

Sec. 15. (NEW) (*Effective from passage*) (a) The purposes of the exchange shall be to reduce the number of individuals without health insurance in this state and assist small employers in the procurement and administration of health insurance by, among other services, offering easily comparable and understandable health insurance options to individuals and small employers, and enrolling individuals in medical assistance programs. For such purposes, the exchange is authorized and empowered to:

(1) Have perpetual succession as a body politic and corporate and to adopt bylaws for the regulation of its affairs and the conduct of its business;

(2) Adopt an official seal and alter the same at pleasure;

(3) Maintain an office at such place or places as it may designate;

(4) Sue and be sued in its own name, and plead and be impleaded;

(5) Employ such assistants, agents and other employees as may be necessary or desirable, and engage consultants, actuaries, attorneys and appraisers as may be necessary or desirable to carry out its purposes in accordance with sections 12 to 20, inclusive, of this act;

(6) Make and enter into a contract or agreement with one or more entities to perform the following services: Premium billing and collection, enrollment, data processing and customer relations management;

(7) Enter into a contract or agreement with any state agency to carry out the purposes of sections 12 to 20, inclusive, of this act;

(8) Solicit, receive and accept aid, grants or contributions from any source of money, property, labor or other things of value, to be held, used and applied to carry out the purposes of sections 12 to 20, inclusive, of this act, subject to such conditions upon which such aid, grants or contributions may be made, including, but not limited to, gifts or grants from any philanthropic organization, department, agency or instrumentality of the United States or this state;

(9) Acquire, lease, purchase, own, manage, hold and dispose of real and personal property, and lease, convey or deal in or enter into agreements with respect to such property on any terms necessary or incidental to the carrying out of these purposes, provided all such acquisitions of real property for the exchange's own use with amounts appropriated by this state to the exchange or with the proceeds of bonds supported by the full faith and credit of this state shall be subject to the approval of the Secretary of the Office of Policy and Management and the provisions of section 4b-23 of the general statutes;

(10) Borrow money for the purpose of obtaining working capital;

(11) Procure insurance against any liability or loss in connection with its property and other assets, in such amounts and from such insurers as it deems desirable;

(12) Account for and audit funds of the exchange and funds of any recipients of funds from the exchange;

(13) Commission surveys of consumers, employers and providers on issues related to health care and health care coverage;

(14) Facilitate the purchase of qualified health plans by individuals and small employers on and after January 1, 2014;

(15) Charge assessments or user fees to insurers on or before January 1, 2015, to meet the cost of administering the exchange;

(16) Limit the number of plans offered, and use selective criteria in determining which plans to offer, through the exchange, provided consumers have an adequate number and selection of choices; and

(17) Do all acts and things necessary or convenient and establish any policy or procedure to carry out the purposes of the exchange, provided such policies and procedures do not conflict with the Affordable Care Act, regulations adopted thereunder or any federal guidance issued pursuant to the Affordable Care Act.

(b) In addition to the powers vested in the exchange under subsection (a) of this section, the exchange shall:

(1) Comply with all provisions of sections 12 to 20, inclusive, of this act, the Affordable Care Act and any regulations adopted thereunder or federal guidance issued pursuant to the Affordable Care Act;

(2) Apply for planning and establishment grants made available under Section 1311 of the Affordable Care Act;

(3) Make qualified health plans available to qualified individuals and qualified employers on or before January 1, 2014;

(4) Rate each qualified health plan and determine each qualified health plan's level of coverage in accordance with the Affordable Care Act;

(5) Perform duties required by the United States Department of Health and Human Services with respect to determining eligibility for individuals for premium tax credits, cost-sharing reduction or individual responsibility requirement exemptions set forth in the Affordable Care Act;

(6) Credit the amount of any free-choice voucher to the monthly premium of the plan in which a qualified employee is enrolled in accordance with the Affordable Care Act and collect the amount credited from such employee's employer;

(7) Report at least annually to the General Assembly on the effect of adverse selection on the operations of the exchange and make legislative recommendations, if necessary, to reduce the negative impact from any such adverse selection on the sustainability of the exchange, including recommendations to ensure that regulation of insurers and health benefit plans are similar for qualified health plans offered through the exchange and health benefit plans offered outside the exchange. The exchange shall evaluate whether adverse selection is occurring with respect to health benefit plans that are grandfathered under the Affordable Care Act, self-insured plans, plans sold through the exchange and plans sold outside the exchange;

(8) Ensure that it does not charge an individual a fee or penalty for terminating coverage if such individual enrolls in another type of minimum essential coverage because (A) the individual has become newly eligible for that coverage, or (B) the individual's employer-sponsored coverage has become affordable under the standards of the Affordable Care Act;

(9) Offer individuals and small employers the option of having the exchange collect and administer premiums, including through allocation of premiums among the various insurers and qualified health plans chosen by individual employees;

(10) Establish procedures by which individuals and small employers may purchase qualified health plans offered through the exchange

through an insurance producer or broker; and

(11) Collaborate with the Department of Social Services, to the extent possible, to allow an individual to remain enrolled in such individual's plan and provider network in the event such individual experiences a loss of eligibility of a premium tax credit and becomes eligible for medical assistance under Title XIX of the Social Security Act, as amended from time to time.

(c) Neither the exchange nor its employees shall be subject to regulation under title 38a of the general statutes.

Sec. 16. (NEW) (*Effective from passage*) (a) The exchange shall be administered in a manner that focuses on individual and small employer needs, including (1) providing easily comparable, accurate and objective information about qualified health plans offered through the exchange, (2) assisting individuals and small employers in the selection and purchase of qualified health plans through an Internet web site, a toll-free hotline, publications, in-person consultations and presentations, including in communities where individuals work and live, and (3) awarding Navigator grants, as described in section 17 of this act. The exchange's assistance, whether written or oral, shall be linguistically competent and take into consideration different levels of reading, English-proficiency and Internet skills.

(b) To meet the consumer-focused requirements of the Affordable Care Act, the exchange shall:

(1) Create an Internet web site where individuals and small employers may view coverage options of qualified health plans offered through the exchange, with benefits and costs presented in a standardized format that meets federal requirements for such format;

(2) Make available on the exchange's Internet web site the relative quality and price rating information developed by the United States Department of Health and Human Services for qualified health plans;

(3) Inform consumers of the enrollee satisfaction ratings of a

qualified health plan;

(4) Operate a toll-free hotline for consumer assistance;

(5) Make a calculator available on the exchange's Internet web site to allow individuals to determine the actual cost of a qualified health plan's coverage after applying a premium tax credit, if applicable, and any cost-sharing reduction;

(6) Develop and provide written and oral assistance to individuals and small employers that take into consideration different levels of reading, English-proficiency and Internet skills;

(7) Provide for an initial enrollment period as well as annual and special enrollment periods;

(8) Determine whether an individual seeking health care coverage through the exchange is eligible for medical assistance under Title XIX or XXI of the Social Security Act, as amended from time to time, and if such individual is eligible, enroll the individual in such program;

(9) Grant exemption certifications to individuals who are exempt from the Affordable Care Act's individual responsibility requirement set forth in Section 1411 of the Affordable Care Act;

(10) Enable individuals to apply for and enroll in a health benefit plan, including medical assistance under Title XIX or XXI of the Social Security Act, as amended from time to time, through the Internet, by mail, by phone or in person; and

(11) Refer individuals, where appropriate, to the Office of the Healthcare Advocate or provide information about health benefit plan appeals.

(c) The exchange shall use consumer focus groups before it is operational to ensure its features, such as its Internet web site, works for consumers, particularly those with low incomes and with special needs.

(d) The exchange shall establish a standing consumer advisory committee to provide input to the board of directors of the exchange on consumer-related matters.

(e) The exchange shall establish methods of independently evaluating consumers' experience, including, but not limited to, hiring consultants to act as secret shoppers.

Sec. 17. (NEW) (*Effective from passage*) (a) The exchange shall establish a Navigator grant program that shall award grants to certain entities to market the exchange for the purposes of: (1) Conducting public education activities to raise awareness of the availability of qualified health plans sold through the exchange; (2) distributing fair and impartial information concerning enrollment in qualified health plans; (3) distributing fair and impartial information about the availability of premium tax credits and cost-sharing reductions pursuant to the Affordable Care Act; (4) facilitating enrollment in qualified health plans; (5) referring individuals with a grievance, complaint or question regarding a plan, a plan's coverage or a determination under a plan's coverage to the Office of the Healthcare Advocate or any customer relations unit established by the exchange; and (6) providing information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange.

(b) The exchange shall award Navigator grants, at the sole discretion of the board of directors, to any of the following entities to carry out Navigator functions: (1) A trade, industry or professional association; (2) a community and consumer-focused nonprofit group; (3) a chamber of commerce; (4) a labor union; (5) a small business development center; or (6) an insurance producer or broker licensed in this state. A Navigator shall not be an insurer or receive any consideration directly or indirectly from any insurer in connection with the enrollment of any qualified individual or employees of a qualified employer in a qualified health plan. An eligible entity shall not receive a Navigator grant unless it can demonstrate to the

satisfaction of the board of directors of the exchange that it has existing relationships, or could readily establish such relationships, with small employers and its employees, individuals including uninsured and underinsured individuals, or self-employed individuals likely to be qualified to enroll in a qualified health plan.

(c) A Navigator shall comply with all applicable provisions of the Affordable Care Act, regulations adopted thereunder or federal guidance issued pursuant to the Affordable Care Act.

(d) The exchange shall collaborate with the Secretary of the United States Department of Health and Human Services to develop standards to ensure that the information distributed and provided by Navigators is fair and accurate.

(e) The exchange shall establish performance standards, accountability requirements and maximum grant amounts for Navigators.

Sec. 18. (NEW) (*Effective from passage*) (a) Prior to being eligible to offer qualified health plans through the exchange, insurers shall be approved by the exchange in accordance with criteria and procedures developed by the exchange. Such insurers shall be licensed in this state and in good standing to offer health insurance coverage in this state. Any such criteria shall comply with any relevant Affordable Care Act provision, regulation or guidance. With respect to an insurer seeking to offer individual qualified health plans, such criteria shall require the exchange to consider any excess premium growth outside the exchange as compared to the rate of premium growth of plans offered through the exchange and information reported by other states with respect to premium rate growth. In addition, at a minimum, such criteria shall include requirements that the insurer shall agree to:

(1) To the extent the insurer offers a plan both outside and through the exchange, offer such plans at the same premium rate;

(2) Offer at least one plan at the silver level of coverage and one plan

at the gold level of coverage, as determined under Section 1311(c)(3) of the Affordable Care Act, through the exchange;

(3) Make each qualified health plan offered through the exchange available as a child-only plan at the same coverage level;

(4) Meet marketing standards prescribed by the exchange or the Affordable Care Act and not use practices or benefit designs that discourage enrollment of individuals with significant health needs;

(5) Meet specified quality, quality improvement and accreditation standards;

(6) Meet transparency standards, including disclosure of information in plain language of: (A) Claims payment policies and practices; (B) periodic financial disclosures; (C) data on enrollment; (D) data on disenrollment; (E) data on the number of claims denied; (F) data on rating practices; (G) information on cost-sharing and payments with respect to any out-of-network coverage; (H) information on enrollee and participant rights under Title I of the Affordable Care Act; and (I) other information as required by the Secretary of the United States Department of Health and Human Services;

(7) Receive accreditation within the time period set by the United States Department of Health and Human Services for local performance on clinical quality measures;

(8) Implement a quality improvement plan that provides incentives for improving enrollees' health outcomes, preventing hospital readmissions, improving patient safety and reducing medical errors, and implement wellness and health promotion activities;

(9) Use a uniform enrollment form approved by the United States Department of Health and Human Services;

(10) Use a standard format developed by the United States Department of Health and Human Service for presenting health benefit plan options;

(11) Provide enrollees and the exchange with information regarding any quality measures for health plan performance endorsed under Section 399JJ of the Public Health Service Act, as amended from time to time;

(12) Permit individuals to learn, in a timely manner, upon request, the amount of cost-sharing, including, but not limited to, deductibles, copayments and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet web site and through other means for individuals without access to the Internet;

(13) Offer a dental-only plan only if the plan also covers pediatric dental benefits described in Section 1302(b)(1)(J) of the Affordable Care Act;

(14) Submit to the exchange a justification for any premium increase prior to the implementation of such increase. The insurer shall prominently post such justification on its Internet web site;

(15) Comply with any regulations relating to the duties of the exchange promulgated by the Secretary of the United States Department of Health and Human Services pursuant to Section 1311(d) of the Affordable Care Act; and

(16) Comply with any other requirements the exchange may establish.

(b) The exchange shall not offer a health benefit plan through the exchange without first certifying that such plan has met the eligibility requirements set forth in the Affordable Care Act, this section and any criteria developed by the exchange. Such criteria shall comply with any relevant Affordable Care Act provision, regulation or guidance and, at a minimum, shall include requirements that a qualified health plan shall:

(1) Include, at a minimum, essential benefits as determined under the Affordable Care Act and the coverage mandates required under chapter 700c of the general statutes;

(2) Provide emergency department services without prior authorization or any coverage limit on out-of-network emergency department service providers;

(3) Provide any out-of-network emergency department coverage under the same conditions as in-network cost sharing;

(4) Comply with any Affordable Care Act provisions that set out-of-pocket cost limits;

(5) Meet level of coverage requirements set forth in Section 1302(a)(3) of the Affordable Care Act;

(6) Have an adequate number of providers in the plan's network, including providers that serve predominantly low-income, medically underserved individuals, and provide individuals with information about the availability of in-network and out-of-network providers, where applicable; and

(7) Meet standards set by the exchange regarding premium rates and contract language.

(c) Prior to certifying any health benefit plan, the exchange shall make a determination that making such plan available through the exchange is in the interests of individuals and small employers.

(d) The exchange shall ensure that a plan is not excluded from the exchange (1) on the basis that it is a fee-for-service plan, (2) by imposing premium price controls, or (3) on the basis that it provides costly benefits, or benefits the exchange believes are inappropriate, to prevent an enrollee's death.

(e) The exchange may certify catastrophic plans, as defined in Section 1302(e) of the Affordable Care Act, as qualified benefit plans

for individuals under thirty years of age or who are exempt from the individual responsibility requirement under the Affordable Care Act.

Sec. 19. (NEW) (*Effective from passage*) To promote transparency in the operations and administration of the exchange, the exchange shall:

(1) Consult with stakeholders, including individuals who are knowledgeable about the health care system and have backgrounds or experience in making informed decisions regarding health, medical and scientific matters, individuals with experience in health plan enrollment, small employers and self-employed individuals, state Medicaid officials and advocates with experience in enrolling hard-to-reach populations in public assistance programs, relating to exchange requirements;

(2) Publish on its Internet web site the average costs of licensing, regulatory fees and any other payments required by the exchange and the exchange's administrative costs including funds lost to waste, fraud and abuse;

(3) Keep an accurate accounting of all activity receipts;

(4) Undergo an annual audit by the United States Department of Health and Human Services;

(5) Fully cooperate with any investigation conducted by the Secretary of the United States Department of Health and Human Services or the Inspector General of said department; and

(6) Ensure that its funds are not spent for staff retreats, promotional giveaways, excessive executive compensation or state or federal lobbying.

Sec. 20. (NEW) (*Effective from passage*) (a) The exchange shall coordinate with federal and state agencies and small employers to verify information relating to individuals and small employers with regard to an individual's eligibility for a premium tax credit or cost-sharing reduction by:

(1) Transferring to the Secretary of the Treasury of the United States a list of (A) individuals who are exempt from the individual responsibility requirement, including such individual's Social Security number, (B) individuals who are employed but eligible for the premium tax credit because the individual's employer did not provide minimum essential coverage, the individual could not afford such employer's health benefit plan or the employer did not provide at least a bronze level of coverage, as determined under Section 1311(c)(3) of the Affordable Care Act, (C) the name and Social Security number of each employee who notifies the exchange that such individual has changed employers, and (D) each individual who ceases coverage under a qualified health plan during a plan year and the effective date of such cessation;

(2) Providing to each employer the name of each employee who qualified for a premium tax credit; and

(3) Providing to the Secretary of the United States Department of Health and Human Services information on all exchange applicants for verification of eligibility of such applicants to seek coverage through the exchange. Such information shall include: (A) For all applicants, their names, birth dates and citizenship statuses; (B) for applicants seeking a premium tax credit or cost-sharing reduction, their incomes, family sizes, full-time employment status and reasons for not being covered by an employer-sponsored health benefit plan; and (C) for applicants seeking an exemption from the individual responsibility requirement under the Affordable Care Act, information supporting such exemption request.

(b) If the United States Department of Health and Human Services notifies the exchange that there is an inconsistency in information provided by an applicant, the exchange shall make a reasonable effort to identify and address the causes of the inconsistency by contacting the applicant and by other methods required by said department.

(c) The exchange shall, not later than ninety days after receiving an application, make determinations on the basis of information the

applicant provides with respect to: (1) The applicant's eligibility for a premium tax credit and cost-sharing reduction; (2) the affordability of the applicant's employer's health benefit plan with respect to such applicant; and (3) the applicant's eligibility for an exemption from the individual responsibility requirement under the Affordable Care Act.

(d) If there is an unresolved inconsistency in an application with respect to a premium tax credit or cost-sharing reduction after the initial ninety-day period, the exchange shall notify the applicant of (1) the amount, if any, of a premium tax credit or cost-sharing reduction available to the applicant based on information provided by the United States Department of Health and Human Services, and (2) available appeals procedures.

(e) If there is an inconsistency with respect to an application from an individual seeking an exemption from the individual responsibility requirement under the Affordable Care Act, the exchange shall, not later than ninety days after notification is received from the United States Department of Health and Human Services, notify the individual (1) that the exchange will not issue a certification of exemption, and (2) of available appeals procedures.

(f) The exchange shall notify an employer if it receives notification from the United States Department of Health and Human Services that the employer may be liable for assessments under the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, because the employer failed to provide affordable or minimum essential coverage through an employer-sponsored plan. The exchange shall provide the employer with information about available appeals procedures.

Sec. 21. Subsection (l) of section 1-79 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(l) "Quasi-public agency" means the Connecticut Development

Authority, Connecticut Innovations, Incorporated, Connecticut Health and Education Facilities Authority, Connecticut Higher Education Supplemental Loan Authority, Connecticut Housing Finance Authority, Connecticut Housing Authority, Connecticut Resources Recovery Authority, Lower Fairfield County Convention Center Authority, Capital City Economic Development Authority, Connecticut Lottery Corporation, [and] Health Information Technology Exchange of Connecticut and Connecticut Health Partnership Exchange.

Sec. 22. Subdivision (1) of section 1-120 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(1) "Quasi-public agency" means the Connecticut Development Authority, Connecticut Innovations, Incorporated, Connecticut Health and Educational Facilities Authority, Connecticut Higher Education Supplemental Loan Authority, Connecticut Housing Finance Authority, Connecticut Housing Authority, Connecticut Resources Recovery Authority, Capital City Economic Development Authority, Connecticut Lottery Corporation, [and] Health Information Technology Exchange of Connecticut and Connecticut Health Partnership Exchange.

Sec. 23. Section 1-124 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Connecticut Development Authority, the Connecticut Health and Educational Facilities Authority, the Connecticut Higher Education Supplemental Loan Authority, the Connecticut Housing Finance Authority, the Connecticut Housing Authority, the Connecticut Resources Recovery Authority, the Health Information Technology Exchange of Connecticut, [and] the Capital City Economic Development Authority and the Connecticut Health Partnership Exchange shall not borrow any money or issue any bonds or notes which are guaranteed by the state of Connecticut or for which there is a capital reserve fund of any kind which is in any way contributed to

or guaranteed by the state of Connecticut until and unless such borrowing or issuance is approved by the State Treasurer or the Deputy State Treasurer appointed pursuant to section 3-12. The approval of the State Treasurer or said deputy shall be based on documentation provided by the authority that it has sufficient revenues to (1) pay the principal of and interest on the bonds and notes issued, (2) establish, increase and maintain any reserves deemed by the authority to be advisable to secure the payment of the principal of and interest on such bonds and notes, (3) pay the cost of maintaining, servicing and properly insuring the purpose for which the proceeds of the bonds and notes have been issued, if applicable, and (4) pay such other costs as may be required.

(b) To the extent the Connecticut Development Authority, Connecticut Innovations, Incorporated, Connecticut Higher Education Supplemental Loan Authority, Connecticut Housing Finance Authority, Connecticut Housing Authority, Connecticut Resources Recovery Authority, Connecticut Health and Educational Facilities Authority, the Health Information Technology Exchange of Connecticut, **[**or**]** the Capital City Economic Development Authority or the Connecticut Health Partnership Exchange is permitted by statute and determines to exercise any power to moderate interest rate fluctuations or enter into any investment or program of investment or contract respecting interest rates, currency, cash flow or other similar agreement, including, but not limited to, interest rate or currency swap agreements, the effect of which is to subject a capital reserve fund which is in any way contributed to or guaranteed by the state of Connecticut, to potential liability, such determination shall not be effective until and unless the State Treasurer or his or her deputy appointed pursuant to section 3-12 has approved such agreement or agreements. The approval of the State Treasurer or his or her deputy shall be based on documentation provided by the authority that it has sufficient revenues to meet the financial obligations associated with the agreement or agreements.

Sec. 24. Section 1-125 of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective from passage*):

The directors, officers and employees of the Connecticut Development Authority, Connecticut Innovations, Incorporated, Connecticut Higher Education Supplemental Loan Authority, Connecticut Housing Finance Authority, Connecticut Housing Authority, Connecticut Resources Recovery Authority, including ad hoc members of the Connecticut Resources Recovery Authority, Connecticut Health and Educational Facilities Authority, Capital City Economic Development Authority, the Health Information Technology Exchange of Connecticut, **[**and**]** Connecticut Lottery Corporation and Connecticut Health Partnership Exchange and any person executing the bonds or notes of the agency shall not be liable personally on such bonds or notes or be subject to any personal liability or accountability by reason of the issuance thereof, nor shall any director or employee of the agency, including ad hoc members of the Connecticut Resources Recovery Authority, be personally liable for damage or injury, not wanton, reckless, wilful or malicious, caused in the performance of his or her duties and within the scope of his or her employment or appointment as such director, officer or employee, including ad hoc members of the Connecticut Resources Recovery Authority. The agency shall protect, save harmless and indemnify its directors, officers or employees, including ad hoc members of the Connecticut Resources Recovery Authority, from financial loss and expense, including legal fees and costs, if any, arising out of any claim, demand, suit or judgment by reason of alleged negligence or alleged deprivation of any person's civil rights or any other act or omission resulting in damage or injury, if the director, officer or employee, including ad hoc members of the Connecticut Resources Recovery Authority, is found to have been acting in the discharge of his or her duties or within the scope of his or her employment and such act or omission is found not to have been wanton, reckless, wilful or malicious.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	38a-497
Sec. 2	*from passage*	38a-554(a) and (b)
Sec. 3	*from passage*	5-259(a)
Sec. 4	*from passage*	5-259(f)
Sec. 5	*from passage*	38a-476(b)
Sec. 6	*from passage*	38a-553
Sec. 7	*from passage*	38a-564(17)
Sec. 8	*from passage*	38a-477b(b)
Sec. 9	*from passage*	38a-567(1)(D)
Sec. 10	*January 1, 2012*	38a-478l(b)
Sec. 11	*from passage*	New section
Sec. 12	*from passage*	New section
Sec. 13	*from passage*	New section
Sec. 14	*from passage*	New section
Sec. 15	*from passage*	New section
Sec. 16	*from passage*	New section
Sec. 17	*from passage*	New section
Sec. 18	*from passage*	New section
Sec. 19	*from passage*	New section
Sec. 20	*from passage*	New section
Sec. 21	*from passage*	1-79(l)
Sec. 22	*from passage*	1-120(1)
Sec. 23	*from passage*	1-124
Sec. 24	*from passage*	1-125

Statement of Legislative Commissioners:
In section 14(a), "Partnership" was inserted after "Health" for internal consistency; throughout section 14 and in section 15 (a)(9), "authority" was changed to "exchange" for internal consistency.

INS	*Joint Favorable Subst.-LCO C/R*	GAE
GAE	*Joint Favorable C/R*	FIN
FIN	*Joint Favorable*	

OFA Fiscal Note

State Impact: See Below

Municipal Impact: None

Explanation

This bill creates the Connecticut Health Partnership Exchange (the Exchange). The Exchange is a quasi-public agency tasked with implementing the insurance exchange requirements of the federal Patient Protection and Affordable Care Act (PPACA).

The Exchange will have ongoing operational costs that will depend upon the administrative structures that are developed by the board. For purposes of comparison, the Commonwealth of Massachusetts (with roughly twice the population of Connecticut), established a health insurance exchange in 2007. Initial operating costs were $19.5 million in the first year and $29.9 million in the second year. However, the Massachusetts Exchange is tasked with administering a publically subsidized health insurance program, which is outside the scope of this bill. Therefore, the cost of the Connecticut exchange is likely to be proportionately less.

The bill specifies that the Exchange can charge assessments or user fees to insurers to generate necessary funding to support operations. Connecticut has received an exchange planning grant from the federal government of $996,848. Under PPACA, additional federal funds are available to assist states in the implementation of the health insurance exchanges. A consortium of the six New England states has already been granted $35.6 million to develop an on-line gateway to health insurance options.

This bill also makes numerous changes that conform statute to federal requirements and current practices.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

sHB 6323

AN ACT MAKING CONFORMING CHANGES TO THE INSURANCE STATUTES PURSUANT TO THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT, AND ESTABLISHING A STATE HEALTH PARTNERSHIP PROGRAM.

SUMMARY:

This bill establishes the Connecticut Health Partnership Exchange, a quasi-public agency, to satisfy requirements of the federal Patient Protection and Affordable Care Act ("PPACA") (§§ 12-24). Under the bill, an 11-member board of directors manages the exchange, including operating an online marketplace where individuals and small employers can compare and purchase health insurance plans that meet federal requirements beginning in 2014.

The bill also changes various health insurance statutes to conform with the PPACA (§§ 1-10). The changes relate to covering dependent children under health care policies until age 26, not denying coverage to children under age 19 because of a preexisting condition, eliminating lifetime maximums, prohibiting rescissions except in cases of fraud and intentional material misrepresentation, and the definition of medical loss ratio.

Lastly, the bill enables the Insurance Department to enforce PPACA provisions against entities it regulates, including insurers and HMOs. It authorizes the commissioner to adopt regulations (§ 11).

EFFECTIVE DATE: Upon passage, except for the provision redefining "medical loss ratio," which is effective January 1, 2012.

§§ 12-24 – CONNECTICUT HEALTH PARTNERSHIP EXCHANGE

Exchange Creation (§§ 14, 21-24)

The bill creates the Connecticut Health Partnership Exchange (exchange) as a quasi-public agency and subjects it to the statutes governing such agencies. Public funds may be spent to carry out its purposes (see Purposes and Duties below). The exchange is not a state department, institution, or agency.

Under the bill, the exchange will continue as long as it has legal authority to exist and until its existence is terminated by law. Upon the exchange's termination, all its rights and properties pass to and are vested in the state of Connecticut.

Board of Directors (§ 14)

Under the bill, the exchange is managed by an 11-member board of directors. The board must annually elect a chairperson and vice-chairperson from among its members. Board members are not compensated, but are reimbursed for their expenses incurred in performing official duties. Board members are:

1. the social services commissioner or designee;

2. six directors, two each appointed by the governor, Senate president pro tempore, and House speaker; and

3. four directors, one each appointed by the Senate and House majority and minority leaders.

Directors must be appointed by September 1, 2011. Appointed members cannot designate anyone to act in their place.

Board Members' Terms and Meetings. Initial terms of the appointed directors are three years, except for the governor's appointees, who serve four years. Subsequent terms are all for four years, beginning on September 1 of the year appointed. Directors may be reappointed. Vacancies must be filled by the appointing authority for the rest of the term. If an appointing authority does not make an appointment initially or within 90 days of a vacancy, the board must make an appointment by majority vote.

Meetings must be held as specified in the bylaws the board adopts and at other times the chairperson deems necessary. Six directors constitute a quorum to transact business. The board may establish committees, including a finance committee.

Any appointed director who fails to attend three consecutive meetings or 50% of all meetings during a calendar year is deemed to have resigned. The appointing authority may remove members for misfeasance, malfeasance, or willful neglect of duty.

Qualifications. Each appointee must have demonstrated expertise in at least two of the following areas:

1. individual health insurance coverage,
2. small employer health insurance coverage,
3. health benefits plan administration,
4. health care finance,
5. public or private health care delivery system administration, or
6. health insurance plan purchase.

The appointing authority must consider the other appointees' expertise when making an appointment to ensure the board reflects (1) a diversity of expertise and (2) the state's cultural, ethnic, and geographical communities.

Appointees and staff cannot be employed by, consultant to, or affiliated with (1) an insurer, insurance producer or broker, health care provider, health care facility, or health or medical clinic while serving in their positions or (2) a trade association of insurers, insurance producers or brokers, health care providers, health care facilities, or health or medical clinics. Appointees and staff cannot be health care providers unless they receive no compensation as providers and do not have an ownership interest in a professional health care practice.

As a condition of qualifying for the board of directors, an appointee must take the state Constitution oath or affirmation. A record of the oath must be filed in the Secretary of the State's Office.

Surety Bond. The bill requires (1) each director to execute a $50,000 surety bond or (2) the chairperson to execute a blanket position bond covering each director and employee of the exchange. Each bond must be (1) conditioned on the faithful performance of duties, (2) written by a surety company authorized to transact business in the state, (3) approved by the attorney general, and (4) filed with the secretary of the state. The exchange must pay the cost of each bond.

Written Procedures. The board must adopt written procedures in accordance with quasi-public agency law, which requires published notice before action, for:

1. adopting an annual budget and plan of operations, including a requirement for board approval before the budget or plan may take effect;

2. hiring, dismissing, promoting, and compensating employees of the exchange, including an affirmative action policy and a requirement for board approval before a position may be created or a vacancy filled;

3. acquiring real and personal property and personal services, including a requirement that the board approve any nonbudgeted expenditure over $5,000;

4. contracting for financial, legal, and other professional services, including a requirement that the exchange solicit proposals at least once every three years for each service it uses; and

5. the use of surplus funds to the extent authorized under the bill or law.

Required Hiring. The bill requires the chairperson, in consultation with the board, to hire an executive director, chief operations officer,

chief technology and information officer, health plan contracting director, general counsel, and other key executive positions the board determines necessary. The applicants cannot be board members. Each is exempt from classified service.

Except for the executive director, the bill requires the board to set salaries that will attract and retain people with superior qualifications for each position. The board must publish the salaries in its annual budget, which must be posted on the exchange's website. In determining the salaries, the board must use independent outside advisers to conduct salary surveys of comparable health insurance exchanges and relevant labor pools. The board cannot pay more than the highest comparable salary for a similar position as determined by the survey. The bill requires the Department of Administrative Services to review the survey methodology.

The executive director serves at the board's pleasure and is paid the amount the board sets. The executive director supervises the exchange's administrative affairs and technical activities in accordance with the board's directives.

Freedom of Information. The exchange is subject to the Freedom of Information Act, except the following information is not subject to disclosure:

1. the names and applications of individuals and employers seeking coverage through the exchange;

2. individuals' health information; and

3. information exchanged between the exchange and the departments of Social Services, Public Health, and Revenue Services; the Insurance Department; the comptroller; or any other state agency that is subject to confidentiality agreements under contracts entered into pursuant to the bill.

Purposes and Duties (§ 15)

The purposes of the exchange include reducing the number of people without health insurance in the state and assisting small employers with purchasing and administering health insurance.

Authorized Actions. Under the bill, the exchange can:

1. establish a state office;
2. adopt by-laws and an official seal;
3. employ assistants, agents, and other employees and engage consultants, actuaries, attorneys, and appraisers as necessary;
4. enter into contracts or agreements for the following services: premium billing and collection, enrollment, data processing, and customer relations management;
5. enter into contracts or agreements with any state agency;
6. solicit, receive, and accept aid, grants, or contributions from any source;
7. borrow money to obtain working capital;
8. acquire, own, manage, hold, and dispose of real and personal property and lease, convey, deal, or enter into agreements concerning such property on any terms necessary to carry out these purposes, except acquisitions of real property that use state-appropriated funds or bond proceeds backed by the state's full faith and credit are subject to the Office of Policy and Management (OPM) secretary's approval;
9. obtain insurance against loss concerning its property and other assets;
10. sue, be sued, implead, and be impleaded;
11. account for and audit exchange funds and any recipients of exchange funds;

12. commission surveys of consumers, employers, and health care providers on issues related to health care and health care coverage;

13. facilitate the purchase of qualified health plans by individuals and small employers on and after January 1, 2014;

14. assess insurers or charge insurers user fees by January 1, 2015 to fund the exchange's administration costs;

15. limit the number of plans offered through the exchange using selective criteria, so long as customers have an adequate selection of plans; and

16. do all acts necessary and convenient to carry out its purposes.

Required Actions. The exchange must:

1. comply with the bill, PPACA, and related federal regulations and guidance;

2. apply for federal exchange planning and establishment grants;

3. make qualified health plans available to qualified individuals and employers by January 1, 2014;

4. rate each qualified plan and determine the level of coverage for each in accordance with federal law;

5. determine eligibility for premium tax credits, cost-sharing reductions, and mandatory insurance exemptions;

6. credit the amount of any "free-choice voucher" to the monthly premium for a qualified employee and collect the amount credited from the employee's employer (see below);

7. not charge an individual a fee or penalty for terminating coverage if the individual enrolls in another type of minimum essential coverage because (a) the individual has become newly

eligible for that coverage or (b) the individual's employer-sponsored coverage has become affordable under the standards of the PPACA;

8. offer individuals and small employers the option of having the exchange collect and administer premiums;

9. establish procedures by which individuals and small employers can buy an exchange plan through an insurance producer or broker; and

10. collaborate, if possible, with the Department of Social Services to allow an individual to stay enrolled in his or her plan and provider network if he or she loses premium tax credit eligibility and becomes eligible for Medicaid.

(Under PPACA, employers must offer certain employees a "free choice voucher." The employee can use the voucher to purchase a qualified health plan on the exchange.)

Report on Adverse Selection. The exchange must report at least annually to the legislature on (1) the effect of adverse selection on the exchange and (2) any necessary legislative recommendations to reduce the negative effect of any adverse selection. The report must include recommendations to ensure that regulation of insurers and health benefit plans are similar for qualified health plans offered through the exchange and health benefit plans offered outside the exchange. The exchange must evaluate whether adverse selection is occurring with respect to health benefit plans that are grandfathered under the PPACA, self-insured plans, plans sold through the exchange, and plans sold outside the exchange.

Regulation. The bill specifies that the exchange and its employees are not subject to regulation under Title 38a, the insurance statutes. (Thus, the exchange is not regulated as an insurance company.)

Consumer Focus of Exchange (§ 16)

Under the bill, the exchange must be administered in a way that focuses on individual and small employer needs. It must:

1. provide easily comparable, accurate, and objective information about qualified health plans it offers;

2. help individuals and small employers select and purchase qualified health plans through an Internet website, a toll-free hotline, publications, in-person consultations, and presentations; and

3. award "navigator" grants (see below).

The exchange's assistance must be linguistically competent and take into consideration different levels of reading, English proficiency, and Internet skills.

Consumer-Focused Requirements. The exchange must:

1. create an Internet website on which individuals and small employers can compare costs and benefits of qualified health plans in a standardized format that meets federal requirements;

2. post on the website the relative quality and price rating information for qualified health plans developed by the U.S. Department of Health and Human Services (HHS);

3. inform consumers of enrollee satisfaction ratings for qualified health plans;

4. operate a toll-free consumer assistance hotline;

5. have available on the website a calculator that allows individuals to determine the actual cost of a qualified health plan, taking into consideration any applicable premium tax credit and cost-sharing reduction;

6. develop and provide consumer assistance that takes into consideration different levels of reading, English-proficiency,

and Internet skills;

7. provide for initial, annual, and special enrollment periods;

8. determine if an applicant for health care coverage is eligible for Medicaid or the State Children's Health Insurance Program (SCHIP) and enroll eligible applicants in those programs;

9. enable an eligible person to apply for and enroll in a health benefit plan through the Internet, by mail or phone, or in person;

10. certify whether an individual is exempt from the PPACA's requirement to carry health insurance (e.g., the person has a qualifying religious exemption, is not in the United States lawfully, or is incarcerated); and

11. refer individuals to the healthcare advocate, where appropriate, or provide information about health benefit plan appeals.

Consumer Focus Groups. Before it begins operations, the exchange must use consumer focus groups to ensure its features, including its website, works for consumers, particularly low-income and special needs consumers.

Consumer Advisory Committee. The exchange must establish a standing consumer advisory committee to provide the directors with input on consumer-related matters.

Secret Shoppers. The exchange must develop ways to independently evaluate consumers' experiences with the exchange, including hiring secret shoppers.

Navigator Grant Program (§ 17)

The bill requires the exchange to establish a "navigator" grant program to award grants to certain entities to market the exchange. The exchange must establish performance standards, accountability requirements, and maximum grant amounts.

Purpose. A navigator must:

1. conduct public education activities about the availability of qualified health plans sold through the exchange;

2. distribute fair and impartial information about enrollment in qualified health plans and the availability of premium tax credits and cost-sharing reductions under the federal PPACA;

3. facilitate enrollment in qualified health plans;

4. refer individuals with a grievance, complaint, or question about a plan, a plan's coverage, or a determination under a plan's coverage to the healthcare advocate or any customer relations unit the exchange establishes; and

5. provide information in a culturally and linguistically appropriate manner.

Entities Allowed as Navigators. The bill requires the exchange board to award navigator grants at the board's sole discretion to any of the following:

1. a trade, industry, or professional association;

2. a community and consumer-focused nonprofit group;

3. a chamber of commerce;

4. a labor union;

5. a small business development center; or

6. an insurance producer or broker licensed in Connecticut.

Under the bill, a navigator cannot (1) be an insurer or (2) receive any consideration directly or indirectly from an insurer for enrolling people in a qualified health plan.

To be considered for a navigator award, an entity must demonstrate

to the board's satisfaction that it has, or could develop, relationships, with small employers, their employees, and individuals, including underinsured, uninsured, or self-insured individuals.

Miscellaneous. The bill requires a navigator to comply with the PPACA and related federal regulations and guidance and it requires the exchange to collaborate with HHS to develop standards that ensure the information navigators provide is fair and accurate.

Qualified Health Plans (§ 18)

The bill defines a "qualified health plan" as a health benefit plan certified as meeting criteria outlined in the PPACA and this bill.

Insurer Requirements. To be eligible to offer qualified health plans through the exchange, an insurer must be (1) approved by the exchange, (2) licensed in Connecticut, and (3) in good standing to offer health insurance in the state. The exchange must develop approval criteria and procedures. Any such criteria must comply with the PPACA and related federal regulations and guidance.

The exchange's criteria for an insurer wanting to offer individual qualified health plans must consider (1) the insurer's excess premium growth for plans offered outside the exchange as compared to the rate of premium growth for plans offered through the exchange and (2) information from other states about the insurer's premium growth rate. (The bill does not define "excess premium growth.")

The approval criteria must also require the insurer to:

1. if it offers plans both outside and through the exchange, offer the plans at the same premium rate;

2. offer through the exchange at least one plan at the silver coverage level (covering 70% of the cost of essential health benefits) and one plan at the gold coverage level (covering 80% of the cost of essential health benefits);

3. make available as a child-only policy each qualified health plan

offered through the exchange;

4. meet marketing standards prescribed by the exchange or the PPACA and not use practices or benefit designs that discourage enrollment of people with significant health needs;

5. meet specified quality, quality improvement, and accreditation standards;

6. meet transparency standards, including disclosing information in plain language about claims, finances, enrollment, rating practices, out-of-network coverage cost sharing, enrollee rights under PPACA, and other information HHS requires;

7. receive, within the timeframe HHS sets, accreditation for local performance on clinical quality measures;

8. implement a quality improvement plan that provides incentives for improving enrollees' health outcomes, preventing hospital readmissions, improving patient safety, reducing medical errors, and implementing wellness and health promotion activities;

9. use a uniform, HHS-approved enrollment form;

10. use an HHS-developed standard format for presenting health benefit options;

11. provide enrollees and the exchange with information on quality measures for health plan performance as endorsed under federal law;

12. inform individuals, upon request, of the amount of cost-sharing (e.g., deductibles, copayments, and coinsurance) they are responsible for under their plans for specific services;

13. offer a dental-only plan if it covers pediatric dental benefits;

14. submit to the exchange and post on the insurer's website a justification for any premium increase before implementing the

increase; and

15. comply with federal regulations relating to the exchange and any other requirements the exchange establishes.

Certification Requirements. Under the bill, the exchange cannot offer a health benefit plan unless it certifies that the plan meets federal, state, and exchange requirements. At a minimum, the certification criteria must require a qualified health plan to:

1. cover federally designated essential health benefits and state benefit mandates;

2. provide emergency department services without prior authorization or any coverage limit on out-of-network emergency department service providers;

3. provide any out-of-network emergency department coverage under the same conditions as in-network cost sharing;

4. comply with any PPACA out-of-pocket cost limits and level of coverage requirements;

5. have an adequate number of providers in its network, including providers that serve predominantly low-income and medically underserved individuals, and provide individuals with information about the availability of in-network and out-of-network providers, where applicable; and

6. meet standards set by the exchange regarding premium rates and contract language.

Before certifying a health benefit plan, the exchange must determine that making the plan available is in the interests of individuals and small employers.

The exchange cannot exclude a plan (1) because it is a fee-for-service plan, (2) by imposing premium price controls, or (3) because it provides benefits to prevent an enrollee's death that are costly or

inappropriate.

The exchange may certify a catastrophic plan only for individuals (1) under age 30 or (2) exempt from the PPACA's requirement to carry health insurance.

Exchange Transparency (§ 19)

The bill requires the exchange to promote transparency in its operations and administration by:

1. consulting with stakeholders on exchange requirements;
2. publishing on its website the average costs of licensing, regulatory fees, and any other payments required by the exchange and the exchange's administrative costs, including funds lost to waste, fraud, and abuse;
3. keeping an accurate accounting of all activity receipts;
4. submitting to an annual HHS audit;
5. fully cooperating with any HHS investigation; and
6. ensuring that its funds are not spent for staff retreats, promotional giveaways, excessive executive compensation, or state or federal lobbying.

Premium Tax Credits and Cost-Sharing Reductions. The bill requires the exchange to coordinate with federal and state agencies and small employers to verify information relating to individuals' and small employers' eligibility for premium tax credits and cost-sharing reductions.

The exchange must give the U.S. Treasury secretary a list of:

1. individuals exempt from the PPACA's requirement to carry health insurance, including their Social Security numbers;
2. individuals employed but eligible for the premium tax credit

because the individual's employer did not provide minimum essential coverage, the individual could not afford such employer's health benefit plan, or the employer did not provide at least a bronze level of coverage;

3. the name and Social Security number of each employee who notifies the exchange that he or she has changed employers; and

4. the name of each individual who ceases coverage under a qualified health plan during a plan year and the cessation's effective date.

The exchange must provide (1) each employer the name of each employee who qualified for a premium tax credit and (2) HHS information on all exchange applicants to verify eligibility. The information provided to HHS must include:

1. the applicants' names, birth dates, and citizenship statuses;

2. for applicants seeking a premium tax credit or cost-sharing reduction, their incomes, family sizes, full-time employment status, and reasons for not being covered by an employer-sponsored health benefit plan; and

3. for applicants seeking an exemption from the PPACA's requirement to carry health insurance, information supporting the exemption request.

If HHS notifies the exchange that the information the applicant provided is inconsistent, the exchange must make a reasonable effort to identify and address the causes of the inconsistency.

Application Decisions and Notifications. The exchange must, within 90 days after receiving an application, determine (1) the applicant's eligibility for a premium tax credit and cost-sharing reduction, (2) the affordability of the applicant's employer's health benefit plan, and (3) the applicant's eligibility for an exemption from the PPACA's requirement to carry health insurance.

If an application contains an unresolved inconsistency concerning a premium tax credit or cost-sharing reduction after the initial 90-day period, the exchange must notify the applicant of the (1) amount, if any, of a premium tax credit or cost-sharing reduction available to him or her based on information provided by HHS and (2) available appeals procedures.

If an application contains an inconsistency concerning an individual seeking an exemption from the PPACA requirement to carry health insurance, the exchange must, within 90 days after receiving notification from HHS, notify the applicant (1) that the exchange will not issue a certification of exemption and (2) of available appeals procedures.

If HHS informs the exchange that an employer may be liable for assessments under the Internal Revenue Code because the employer failed to provide affordable or minimum essential coverage through an employer-sponsored plan, the exchange must notify the employer and provide information about available appeals procedures.

§§ 1-10 – CONFORMING CHANGES TO COMPLY WITH PPACA

Dependents to Age 26 (§§ 1-4)

Under the federal PPACA, children may stay on a parent's health insurance plan until age 26. The bill revises various insurance statutes to comply with this requirement. Current state law restricts a child's coverage based on his or her marriage or residency status.

Preexisting Conditions (§§ 5-7)

Under the federal PPACA, insurers cannot impose a preexisting condition limitation that excludes coverage for children under age 19. The bill revises various insurance statutes to comply with this requirement.

The bill makes various definitions of preexisting conditions provision consistent throughout the insurance statutes. It defines a preexisting condition as a condition, whether physical or mental, for which medical advice, diagnosis, or care or treatment was previously

recommended or received during a specified period. For individual and group health insurance policies, that period is the six months immediately preceding the effective date of coverage.

Comprehensive Health Care Plans (§ 6)

Lifetime Limits. Under the federal PPACA, health benefit plans cannot impose lifetime limits on the dollar value of essential health benefits, to be defined by HHS. To conform to the federal requirement, the bill prohibits individual and group comprehensive health care plans from imposing such a lifetime limit. It specifies that a plan may include a lifetime limit of at least $1 million on benefits that are not essential health care benefits as defined by PPACA and related regulations.

Mental Health Benefits. The bill eliminates specific provisions that allow mental health benefits to vary from benefits for physical conditions. Thus, it requires comprehensive health care plans to provide mental health benefits on the same terms as physical benefits.

Pregnancy. The bill removes a provision that requires comprehensive health care plans to limit pregnancy benefits to $250. Thus, it requires the plans to cover pregnancy on the same basis as other conditions.

Rescissions (§§ 8 and 9)

The federal PPACA limits policy rescissions (e.g., retrospective policy cancellations) to instances of fraud and intentional material misrepresentation.

Under state law, an insurer or HMO must obtain the insurance commissioner's approval for a policy rescission, cancellation, or limitation. The bill requires the commissioner to approve a request for rescission or limitation when the insured or the insured's representative (1) submitted fraudulent (rather than false) information on an insurance application, (2) intentionally (rather than knowingly) misrepresented material information on the application, or (3) intentionally (rather than knowingly) omitted material information

from the application. He must approve a cancellation in accordance with federal law, which requires prior notification to the insured.

Medical Loss Ratio (§ 10)

The Insurance Department publishes an annual Consumer Report Card on Health Insurance Carriers in Connecticut. By law, the report card must include each insurer's and HMO's medical loss ratio. The bill specifies that "medical loss ratio" has the meaning provided in the federal PPACA.

"Medical loss ratio" is generally the percentage of premium dollars that an insurer or HMO spends on providing health care and health care quality improvement activities, versus how much is spent on administrative and overhead costs.

BACKGROUND

Related Bills

The Insurance and Real Estate Committee reported out SB 921, which similarly creates an exchange as a quasi-public agency. The committee also reported out sSB 1158, which contains the same rescission provisions as this bill.

The Public Health Committee reported out sSB 1204, which similarly creates an exchange as a quasi-public agency.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Change of Reference
Yea 14 Nay 3 (03/10/2011)

Government Administration and Elections Committee

Joint Favorable Change of Reference
Yea 10 Nay 4 (03/23/2011)

Finance, Revenue and Bonding Committee

Joint Favorable
Yea 34 Nay 18 (04/07/2011)