



Senate

General Assembly

File No. 802

January Session, 2011

Substitute Senate Bill No. 1204

Senate, May 16, 2011

The Committee on Appropriations reported through SEN. HARP of the 10th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT ESTABLISHING THE CONNECTICUT HEALTH INSURANCE EXCHANGE.

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

- 1 Section 1. (NEW) (*Effective from passage*) For purposes of this section
2 and sections 2 to 13, inclusive, of this act:
- 3 (1) "Board" means the board of directors of the Connecticut Health
4 Insurance Exchange;
- 5 (2) "Commissioner" means the Insurance Commissioner;
- 6 (3) "Exchange" means the Connecticut Health Insurance Exchange
7 established pursuant to section 2 of this act;
- 8 (4) "Federal act" means the Patient Protection and Affordable Care
9 Act, P.L. 111-148, as amended by the Health Care and Education
10 Reconciliation Act, P.L. 111-152, as both may be amended from time to
11 time, and regulations adopted thereunder;

12 (5) (A) "Health benefit plan" means an insurance policy or contract
13 offered, delivered, issued for delivery, renewed, amended or
14 continued in the state by a health carrier to provide, deliver, pay for or
15 reimburse any of the costs of health care services.

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

17 (i) Coverage of the type specified in subdivisions (5), (6), (7), (8), (9),
18 (14), (15) and (16) of section 38a-469 of the general statutes or any
19 combination thereof;

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

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

23 (iv) Workers' compensation insurance;

24 (v) Automobile medical payment insurance;

25 (vi) Credit insurance;

26 (vii) Coverage for on-site medical clinics; or

27 (viii) Other similar insurance coverage specified in regulations
28 issued pursuant to the Health Insurance Portability and Accountability
29 Act of 1996, P.L. 104-191, as amended from time to time, under which
30 benefits for health care services are secondary or incidental to other
31 insurance benefits.

32 (C) "Health benefit plan" does not include the following benefits if
33 they are provided under a separate insurance policy, certificate or
34 contract or are otherwise not an integral part of the plan:

35 (i) Limited scope dental or vision benefits;

36 (ii) Benefits for long-term care, nursing home care, home health
37 care, community-based care or any combination thereof; or

38 (iii) Other similar, limited benefits specified in regulations issued

39 pursuant to the Health Insurance Portability and Accountability Act of
40 1996, P.L. 104-191, as amended from time to time;

41 (iv) Other supplemental coverage, similar to coverage of the type
42 specified in subdivisions (9) and (14) of section 38a-469 of the general
43 statutes, provided under a group health plan.

44 (D) "Health benefit plan" does not include coverage of the type
45 specified in subdivisions (3) and (13) of section 38a-469 of the general
46 statutes or other fixed indemnity insurance if (i) such coverage is
47 provided under a separate insurance policy, certificate or contract, (ii)
48 there is no coordination between the provision of the benefits and any
49 exclusion of benefits under any group health plan maintained by the
50 same plan sponsor, and (iii) the benefits are paid with respect to an
51 event without regard to whether benefits were also provided under
52 any group health plan maintained by the same plan sponsor;

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

55 (7) "Health carrier" means an insurance company, fraternal benefit
56 society, hospital service corporation, medical service corporation
57 health care center or other entity subject to the insurance laws and
58 regulations of the state or the jurisdiction of the commissioner that
59 contracts or offers to contract to provide, deliver, pay for or reimburse
60 any of the costs of health care services;

61 (8) "Internal Revenue Code" means the Internal Revenue Code of
62 1986, or any subsequent corresponding internal revenue code of the
63 United States, as amended from time to time;

64 (9) "Navigator" means a person or entity participating in the grant
65 program established in accordance with section 7 of this act and
66 Section 3510 of the federal act;

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

69 (11) "Qualified dental plan" means a limited scope dental plan that
70 has been certified in accordance with subsection (e) of section 9 of this
71 act;

72 (12) "Qualified employer" means a small employer that elects to
73 make its full-time employees eligible for one or more qualified health
74 plans offered through the exchange, and at the option of the employer,
75 some or all of its part-time employees, provided the employer:

76 (A) Has its principal place of business in the state and elects to
77 provide coverage through the exchange to all of its eligible employees,
78 wherever employed; or

79 (B) Elects to provide coverage through the exchange to all of its
80 eligible employees who are principally employed in the state;

81 (13) "Qualified health plan" means a health benefit plan that has in
82 effect a certification that the plan meets the criteria for certification
83 described in Section 1311(c) of the federal act and section 8 of this act;

84 (14) "Qualified individual" has the same meaning as provided in
85 Section 1312 of the federal act;

86 (15) "Secretary" means the Secretary of the United States
87 Department of Health and Human Services; and

88 (16) (A) "Small employer" means an employer that employed an
89 average of not more than fifty employees during the preceding
90 calendar year.

91 (B) For purposes of this subdivision:

92 (i) All persons treated as a single employer under Section 414(b), (c),
93 (m) or (o) of the Internal Revenue Code shall be treated as a single
94 employer;

95 (ii) An employer and any predecessor employer shall be treated as a
96 single employer;

97 (iii) All employees shall be counted, including part-time employees
98 and employees who are not eligible for coverage through the
99 employer;

100 (iv) If an employer was not in existence throughout the preceding
101 calendar year, the determination of whether such employer is a small
102 employer shall be based on the average number of employees that is
103 reasonably expected such employer will employ on business days in
104 the current calendar year; and

105 (v) An employer that makes enrollment in qualified health plans
106 available to its employees through the exchange, and would cease to
107 be a small employer by reason of an increase in the number of its
108 employees, shall continue to be treated as a small employer for
109 purposes of this section and sections 2 to 13, inclusive, of this act as
110 long as it continuously makes enrollment through the exchange
111 available to its employees.

112 Sec. 2. (NEW) (*Effective from passage*) (a) There is hereby created as a
113 body politic and corporate, constituting a public instrumentality and
114 political subdivision of the state created for the performance of an
115 essential public and governmental function, to be known as the
116 Connecticut Health Insurance Exchange. The purposes of the
117 Connecticut Health Insurance Exchange shall be to reduce the number
118 of individuals without health insurance in this state and assist small
119 employers in the procurement and administration of health insurance
120 by, among other services, offering easily comparable and
121 understandable health insurance options to individuals and small
122 employers, and enrolling individuals in medical assistance programs.
123 The Connecticut Health Insurance Exchange shall be a solvent and
124 self-sustaining entity on or before January 1, 2015. The Connecticut
125 Health Insurance Exchange shall not be construed to be a department,
126 institution or agency of the state.

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

130 (A) The Governor shall appoint one director who shall serve an
131 initial term of three years;

132 (B) The president pro tempore of the Senate shall appoint one
133 director who shall serve an initial term of four years;

134 (C) The speaker of the House of Representatives shall appoint one
135 director who shall serve an initial term of four years;

136 (D) The majority leader of the Senate shall appoint one director who
137 shall serve an initial term of four years;

138 (E) The majority leader of the House of Representatives shall
139 appoint one director who shall serve an initial term of four years;

140 (F) The minority leader of the Senate shall appoint one director who
141 shall serve an initial term of three years;

142 (G) The minority leader of the House of Representatives shall
143 appoint one director who shall serve an initial term of three years; and

144 (H) The Commissioners of Social Services and Public Health, the
145 Insurance Commissioner, or the commissioners' designees, the
146 Secretary of the Office of Policy and Management, or the secretary's
147 designee and the Healthcare Advocate, or the Healthcare Advocate's
148 designee who shall serve as ex-officio nonvoting directors.

149 (2) Following the expiration of such initial terms, subsequent
150 director terms shall be for four years, commencing on October first of
151 the year of the appointment. If an appointing authority fails to make
152 an initial appointment to the board or an appointment to fill a board
153 vacancy within ninety days of the date of such vacancy, the appointed
154 directors shall, by majority vote, make such appointment to the board.
155 Any director previously appointed to the exchange board of directors
156 may be reappointed in accordance with this subsection.

157 (3) Each appointee, other than the commissioners and the secretary,
158 shall have demonstrated expertise in at least two of the following

159 areas: (A) Individual health insurance coverage; (B) small employer
160 health insurance coverage; (C) health benefits plan administration; (D)
161 health care finance; (E) public or private health care delivery system
162 administration; or (F) health insurance plan purchase. When making
163 an appointment, the appointing authority shall consider the expertise
164 of the other directors to ensure the board's composition reflects a
165 diversity of expertise and the cultural, ethnic and geographical
166 communities of this state.

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

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

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

188 (c) As a condition of qualifying as a member of the board of
189 directors of the exchange, each appointee shall, before entering upon
190 such member's duties, take and subscribe the oath or affirmation
191 required under section 1 of article eleventh of the Constitution of the

192 state. A record of each such oath shall be filed in the office of the
193 Secretary of the State. Meetings of the board of directors shall be held
194 at such times as shall be specified in the bylaws adopted by the board
195 and at such other time or times as the chairperson deems necessary.

196 (d) The board of directors shall select a chairperson every two years
197 from among the board members. The chairperson shall schedule the
198 first meeting of the board, which meeting shall be held not later than
199 October 1, 2011. Any board member who fails to attend three
200 consecutive meetings or who fails to attend fifty per cent of all
201 meetings held during any calendar year shall be deemed to have
202 resigned from the board.

203 (e) Board members shall receive no compensation for their services
204 but shall receive actual and necessary expenses incurred in the
205 performance of their official duties.

206 (f) Four directors of the exchange shall constitute a quorum for the
207 transaction of any business or the exercise of any power of the
208 exchange. For the transaction of any business or the exercise of any
209 power of the exchange, the exchange may act by a majority of the
210 directors present at any meeting at which a quorum is in attendance.
211 No vacancy in the membership of the board of directors shall impair
212 the right of such directors to exercise all the rights and perform all the
213 duties of the board. Any action taken by the board under the
214 provisions of sections 1 to 13, inclusive, of this act may be authorized
215 by resolution approved by a majority of the directors present at any
216 regular or special meeting, which resolution shall take effect
217 immediately unless otherwise provided in the resolution.

218 (g) The board shall select and appoint a chief executive officer who
219 shall be responsible for administering the exchange's programs and
220 activities in accordance with policies and objectives established by the
221 board. The chief executive officer shall serve at the pleasure of the
222 board and shall receive such compensation as shall be determined by
223 the board. The chief executive officer (1) may employ such other
224 employees as shall be designated by the board of directors, and (2)

225 shall attend all meetings of the board, keep a record of all proceedings
226 and maintain and be custodian of all records, books, documents and
227 papers filed with or compiled by the exchange.

228 (h) The board may consult with such parties, public or private, as it
229 deems desirable or necessary in exercising its duties under sections 1
230 to 13, inclusive, of this act.

231 (i) The board may create such advisory committees as it deems
232 necessary to represent key stakeholders that may include, but need not
233 be limited to, consumers, small employers, the insurance industry and
234 health care providers.

235 Sec. 3. (NEW) (*Effective from passage*) The board of directors of the
236 exchange shall adopt written procedures, in accordance with the
237 provisions of section 1-121 of the general statutes, for: (1) Adopting an
238 annual budget and plan of operations, including a requirement of
239 board approval before the budget or plan may take effect; (2) hiring,
240 dismissing, promoting and compensating employees of the exchange,
241 including an affirmative action policy and a requirement of board
242 approval before a position may be created or a vacancy filled; (3)
243 acquiring real and personal property and personal services, including
244 a requirement of board approval for any nonbudgeted expenditure in
245 excess of five thousand dollars; (4) contracting for financial, legal, bond
246 underwriting and other professional services, including a requirement
247 that the exchange solicit proposals at least once every three years for
248 each such service which it uses; (5) issuing and retiring bonds, bond
249 anticipation notes and other obligations of the exchange; (6)
250 establishing requirements for certification of qualified health plans that
251 include, but are not limited to, minimum standards for marketing
252 practices, network adequacy, essential community providers in
253 underserved areas, accreditation, quality improvement, uniform
254 enrollment forms and descriptions of coverage, and quality measures
255 for health benefit plan performance; and (7) implementing the
256 provisions of sections 1 to 13, inclusive, of this act or other provisions
257 of the general statutes. Any such written procedures adopted pursuant

258 to subdivision (7) of this section shall not conflict with or prevent the
259 application of regulations promulgated by the Secretary under the
260 federal act.

261 Sec. 4. (NEW) (*Effective from passage*) The board of directors of the
262 exchange shall require that the exchange be audited annually by the
263 United States Department of Health and Human Services. The board of
264 directors of the exchange shall submit to the joint standing committee
265 of the General Assembly having cognizance of matters relating to
266 insurance a copy of each audit of the exchange conducted by the
267 United States Department of Health and Human Services and any
268 audit conducted by an independent auditing firm, not later than seven
269 days after the date such audit is received by the board of directors.

270 Sec. 5. (NEW) (*Effective from passage*) (a) For purposes of sections 1 to
271 13, inclusive, of this act, "purposes of the exchange" means the
272 purposes of the exchange expressed in and pursuant to this section,
273 which are hereby determined to be public purposes for which public
274 funds may be expended. The powers enumerated in this section shall
275 be interpreted broadly to effectuate the purposes of the exchange and
276 shall not be construed as a limitation of powers.

277 (b) The exchange is authorized and empowered to:

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

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

282 (3) Maintain an office in the state at such place or places as it may
283 designate;

284 (4) Employ such assistants, agents and other employees as may be
285 necessary or desirable. Nonmanagerial employees of the exchange
286 shall be members of the classified service. Managerial employees of the
287 exchange shall be exempt from the classified service;

288 (5) Engage consultants, attorneys and other experts as may be
289 necessary or desirable to carry out the purposes of the exchange;

290 (6) Acquire, lease, purchase, own, manage, hold and dispose of real
291 and personal property, and lease, convey or deal in or enter into
292 agreements with respect to such property on any terms necessary or
293 incidental to the carrying out of these purposes;

294 (7) Receive and accept, from any source, aid or contributions,
295 including money, property, labor and other things of value;

296 (8) Charge assessments or user fees to health carriers or otherwise
297 generate funding necessary to support the operations of the exchange
298 and navigator grants under section 7 of this act;

299 (9) Procure insurance against loss in connection with its property
300 and other assets in such amounts and from such insurers as it deems
301 desirable;

302 (10) Invest any funds not needed for immediate use or disbursement
303 in obligations issued or guaranteed by the United States of America or
304 the state and in obligations that are legal investments for savings banks
305 in the state;

306 (11) Issue bonds, bond anticipation notes and other obligations of
307 the exchange for any of its corporate purposes, and to fund or refund
308 the same and provide for the rights of the holders thereof, and to
309 secure the same by pledge of revenues, notes and mortgages of others;

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

311 (13) Account for and audit funds of the exchange and any recipients
312 of funds from the exchange;

313 (14) Make and enter into any contract or agreement necessary or
314 incidental to the performance of its duties and execution of its powers,
315 including, but not limited to, agreements with the Departments of
316 Revenue Services and Social Services, the Insurance Department, the

317 Labor Department and any other state agency, as deemed necessary by
318 the exchange;

319 (15) To the extent permitted under its contract with other persons,
320 consent to any termination, modification, forgiveness or other change
321 of any term of any contractual right, payment, royalty, contract or
322 agreement of any kind to which the exchange is a party;

323 (16) Award grants to navigators as set forth in section 7 of this act.
324 Applications for grants from the exchange shall be made on a form
325 prescribed by the board. The board shall review applications and
326 decide whether to award a grant. The board may consider, as a
327 condition for awarding a grant, any factors the board deems relevant;

328 (17) Sue and be sued, plead and be impleaded;

329 (18) Adopt regular procedures that are not in conflict with other
330 provisions of the general statutes, for exercising the power of the
331 exchange; and

332 (19) Do all acts and things necessary and convenient to carry out the
333 purposes of the exchange.

334 (c) The exchange shall be subject to the Freedom of Information Act,
335 as defined in section 1-200 of the general statutes, except that the
336 following information shall not be subject to disclosure under section
337 1-210 of the general statutes: (1) The names and applications of
338 individuals and employers seeking coverage through the exchange; (2)
339 individuals' health information; and (3) information exchanged
340 between the exchange and (A) the Departments of Social Services,
341 Public Health and Revenue Services, (B) the Insurance Department, (C)
342 the office of the Comptroller, and (D) any other state agency that is
343 subject to confidentiality agreements under contracts entered into
344 pursuant to this section.

345 Sec. 6. (NEW) (*Effective from passage*) The exchange shall:

346 (1) Implement procedures for the certification, recertification and

347 decertification, consistent with guidelines developed by the Secretary
348 under Section 1311(c) of the federal act, and section 9 of this act, of
349 health benefit plans as qualified health plans;

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

353 (3) Provide for the operation of a toll-free telephone hotline to
354 respond to requests for assistance;

355 (4) Provide for enrollment periods, as provided under Section
356 1311(c)(6) of the federal act;

357 (5) Maintain an Internet web site through which enrollees and
358 prospective enrollees of qualified health plans may (A) obtain
359 standardized comparative information on such plans; (B) access
360 quality and price rating information developed by the United States
361 Department of Health and Human Services for qualified health plans;
362 and (C) access transparent information concerning a qualified health
363 plan's premiums, cost sharing requirements, including deductibles,
364 copayments and coinsurance and coverage limitations, which
365 information shall be contractually binding on the qualified health plan;

366 (6) Publish the average costs of licensing, regulatory fees and any
367 other payments required by the exchange and the administrative costs
368 of the exchange, including information on moneys lost to waste, fraud
369 and abuse, on an Internet web site to educate individuals on such
370 costs;

371 (7) Assign a rating to each qualified health plan offered through the
372 exchange in accordance with the criteria developed by the Secretary
373 under Section 1311(c)(3) of the federal act, and determine each
374 qualified health plan's level of coverage in accordance with regulations
375 issued by the Secretary under Section 1302(d)(2)(A) of the federal act;

376 (8) Use a standardized format for presenting health benefit options
377 in the exchange, including the use of the uniform outline of coverage

378 established under Section 2715 of the Public Health Service Act, 42
379 USC 300gg-15, as amended from time to time;

380 (9) Inform individuals, in accordance with Section 1413 of the
381 federal act, of eligibility requirements for the Medicaid program under
382 Title XIX of the Social Security Act, as amended from time to time, the
383 Children's Health Insurance Program (CHIP) under Title XXI of the
384 Social Security Act, as amended from time to time, or any applicable
385 state or local public program, and enroll an individual in such
386 program if the exchange determines, through screening of the
387 application by the exchange, that such individual is eligible for any
388 such program;

389 (10) Establish and make available by electronic means a calculator to
390 determine the actual cost of coverage after application of any premium
391 tax credit under Section 36B of the Internal Revenue Code and any
392 cost-sharing reduction under Section 1402 of the federal act;

393 (11) Ensure that a qualified employer is permitted to make defined
394 contributions to a health carrier on behalf of an employee enrolling in
395 such qualified health plan;

396 (12) Grant a certification, subject to Section 1411 of the federal act,
397 attesting that, for purposes of the individual responsibility penalty
398 under Section 5000A of the Internal Revenue Code, an individual is
399 exempt from the individual responsibility requirement or from the
400 penalty imposed by said Section 5000A because:

401 (A) There is no affordable qualified health plan available through
402 the exchange, or the individual's employer, covering the individual; or

403 (B) The individual meets the requirements for any other such
404 exemption from the individual responsibility requirement or penalty;

405 (13) Provide to the Secretary of the Treasury of the United States the
406 following:

407 (A) A list of the individuals granted a certification under

408 subdivision (12) of this section, including the name and taxpayer
409 identification number of each individual;

410 (B) The name and taxpayer identification number of each individual
411 who was an employee of an employer but who was determined to be
412 eligible for the premium tax credit under Section 36B of the Internal
413 Revenue Code because:

414 (i) The employer did not provide minimum essential health benefits
415 coverage; or

416 (ii) The employer provided the minimum essential coverage but it
417 was determined under Section 36B(c)(2)(C) of the Internal Revenue
418 Code to be unaffordable to the employee or not provide the required
419 minimum actuarial value; and

420 (C) The name and taxpayer identification number of:

421 (i) Each individual who notifies the exchange under Section
422 1411(b)(4) of the federal act that such individual has changed
423 employers; and

424 (ii) Each individual who ceases coverage under a qualified health
425 plan during a plan year and the effective date of that cessation;

426 (14) Provide to each employer the name of each employee, as
427 described in subparagraph (B) of subdivision (13) of this section, of the
428 employer who ceases coverage under a qualified health plan during a
429 plan year and the effective date of the cessation;

430 (15) Perform duties required of, or delegated to, the exchange by the
431 Secretary or the Secretary of the Treasury of the United States related
432 to determining eligibility for premium tax credits, reduced cost-
433 sharing or individual responsibility requirement exemptions;

434 (16) Select entities qualified to serve as navigators in accordance
435 with Section 1311(i) of the federal act and award grants to enable
436 navigators to carry out the provisions of section 7 of this act;

437 (17) Review the rate of premium growth within and outside the
438 exchange and consider such information in developing
439 recommendations on whether to continue limiting qualified employer
440 status to small employers;

441 (18) Credit the amount, in accordance with Section 10108 of the
442 federal act, of any free choice voucher to the monthly premium of the
443 plan in which a qualified employee is enrolled and collect the amount
444 credited from the offering employer;

445 (19) Consult with stakeholders relevant to carrying out the activities
446 required under sections 1 to 13, inclusive, of this act, including, but not
447 limited to:

448 (A) Individuals who are knowledgeable about the health care
449 system, have background or experience in making informed decisions
450 regarding health, medical and scientific matters and are enrollees in
451 qualified health plans;

452 (B) Individuals and entities with experience in facilitating
453 enrollment in qualified health plans;

454 (C) Groups of small employers and self-employed individuals;

455 (D) The Department of Social Services; and

456 (E) Advocates for enrolling hard-to-reach populations;

457 (20) Establish methods of independently evaluating consumers'
458 experience, including, but not limited to, hiring consultants to act as
459 secret shoppers;

460 (21) Establish (A) rating systems that permit individuals and small
461 employers to compare the value of competing qualified health plans;
462 and (B) plan member satisfaction surveys concerning qualified health
463 plans with particular emphasis on soliciting feedback from plan
464 members who have serious health conditions or who have
465 encountered financial difficulties as a result of serious health

466 conditions; and

467 (22) Meet the following financial integrity requirements:

468 (A) Keep an accurate accounting of all activities, receipts and
469 expenditures and annually submit to the Secretary, the Governor, the
470 Insurance Commissioner and the General Assembly a report
471 concerning such accountings;

472 (B) Fully cooperate with any investigation conducted by the
473 Secretary pursuant to the Secretary's authority under the federal act
474 and allow the Secretary, in coordination with the Inspector General of
475 the United States Department of Health and Human Services, to:

476 (i) Investigate the affairs of the exchange;

477 (ii) Examine the properties and records of the exchange; and

478 (iii) Require periodic reports in relation to the activities undertaken
479 by the exchange; and

480 (C) Not use any funds in carrying out its activities under sections 1
481 to 13, inclusive, of this act, that are intended for the administrative and
482 operational expenses of the exchange, for staff retreats, promotional
483 giveaways, excessive executive compensation or promotion of federal
484 or state legislative and regulatory modifications.

485 Sec. 7. (NEW) (*Effective from passage*) (a) The exchange shall establish
486 a navigator grant program that shall award grants to certain entities to
487 market the exchange for the purposes of: (1) Conducting public
488 education activities to raise awareness of the availability of qualified
489 health plans sold through the exchange; (2) distributing fair and
490 impartial information concerning enrollment in qualified health plans;
491 (3) distributing fair and impartial information about the availability of
492 premium tax credits and cost-sharing reductions pursuant to the
493 federal act; (4) facilitating enrollment in qualified health plans; (5)
494 referring individuals with a grievance, complaint or question
495 regarding a plan, a plan's coverage or a determination under a plan's

496 coverage to the Office of the Healthcare Advocate or any customer
497 relations unit established by the exchange; and (6) providing
498 information in a manner that is culturally and linguistically
499 appropriate to the needs of the population being served by the
500 exchange.

501 (b) The exchange shall award navigator grants, at the sole discretion
502 of the board of directors, to any of the following entities to carry out
503 navigator functions: (1) A trade, industry or professional association;
504 (2) a community and consumer-focused nonprofit group; (3) a
505 chamber of commerce; (4) a labor union; (5) a small business
506 development center; or (6) an insurance producer or broker licensed in
507 this state. A navigator shall not be an insurer or receive any
508 consideration directly or indirectly from any insurer in connection
509 with the enrollment of any qualified individual or employees of a
510 qualified employer in a qualified health plan. An eligible entity shall
511 not receive a navigator grant unless it can demonstrate to the
512 satisfaction of the board of directors of the exchange that it has (A)
513 existing relationships, or could readily establish such relationships,
514 with small employers and their employees, individuals including
515 uninsured and underinsured individuals, or self-employed individuals
516 likely to be qualified to enroll in a qualified health plan, or (B)
517 particular expertise or experience in meeting the health insurance
518 needs of small employers, minority populations, elderly populations
519 and young adults.

520 (c) A navigator shall comply with all applicable provisions of the
521 federal act, regulations adopted thereunder or guidance issued
522 pursuant to the federal act.

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

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

529 navigators.

530 Sec. 8. (NEW) (*Effective from passage*) (a) The exchange shall make
531 qualified health plans available to qualified individuals and qualified
532 employers for coverage beginning on or before January 1, 2014.

533 (b) (1) The exchange shall not make available any health benefit plan
534 that is not a qualified health plan.

535 (2) The exchange shall allow a health carrier to offer a plan that
536 provides limited scope dental benefits meeting the requirements of
537 Section 9832(c)(2)(A) of the Internal Revenue Code through the
538 exchange, either separately or in conjunction with a qualified health
539 plan, if the plan provides pediatric dental benefits meeting the
540 requirements of Section 1302(b)(1)(J) of the federal act.

541 (c) Neither the exchange nor a health carrier offering health benefit
542 plans through the exchange shall charge an individual a fee or penalty
543 for termination of coverage if the individual enrolls in another type of
544 minimum essential coverage because (1) the individual has become
545 newly eligible for that coverage, or (2) the individual's employer-
546 sponsored coverage has become affordable under the standards of
547 Section 36B(c)(2)(C) of the Internal Revenue Code.

548 (d) A qualified employer, participating in the exchange: (1) Shall not
549 offer to its employees outside the exchange coverage under a
550 competing health benefit plan offering the same, or substantially the
551 same, benefits provided through the exchange; (2) reserves the right to
552 determine, subject to applicable state and federal law, (A) employer
553 criteria for eligibility, enrollment and participation in the exchange,
554 and (B) the amount of the employer contributions, if any, to a qualified
555 health plan for employee coverage; (3) shall participate in a payroll
556 deduction program to facilitate the payment of health benefit plan
557 premium payments by employees to benefit from deductibility of
558 gross income under 26 USC 125; and (4) shall make available, in a
559 timely manner, for confidential review by the chief executive officer of
560 the exchange, employer documents, records or other information that

561 the chief executive officer reasonably determines are necessary to
562 verify, (A) that the employer is in compliance with applicable state and
563 federal law relating to the offering of group health benefit plans,
564 particularly provisions of such laws relating to nondiscrimination in
565 coverage, and (B) the eligibility, under the terms of the health benefit
566 plan, of those employees enrolled in such plan.

567 Sec. 9. (NEW) (*Effective from passage*) (a) The exchange may certify a
568 health benefit plan as a qualified health plan if:

569 (1) The plan provides the essential health benefits package, as
570 described in Section 1302(a) of the federal act, and the coverage
571 mandates required under chapter 700c of the general statutes, except
572 that the plan shall not be required to provide essential benefits that
573 duplicate the minimum benefits of qualified dental plans, as set forth
574 in subsection (e) of this section, if:

575 (A) The exchange has determined that at least one qualified dental
576 plan is available to supplement the plan's coverage; and

577 (B) The health carrier makes prominent disclosure at the time it
578 offers the plan, in a form approved by the exchange, that such plan
579 does not provide the full range of essential pediatric benefits, and that
580 qualified dental plans providing those benefits and other dental
581 benefits not covered by such plan are offered through the exchange;

582 (2) The premium rates and contract language have been approved
583 by the commissioner;

584 (3) The plan provides at least a bronze level of coverage, as
585 determined pursuant to subdivision (7) of section 6 of this act, unless
586 the plan is certified as a qualified catastrophic plan, meets the
587 requirements of the federal act for catastrophic plans and will only be
588 offered to individuals eligible for catastrophic coverage;

589 (4) The plan's cost-sharing requirements do not exceed the limits
590 established under Section 1302(c)(1) of the federal act, and the plan's
591 deductibles do not exceed the limits established under Section

592 1302(c)(2) of the federal act;

593 (5) The health carrier offering the plan:

594 (A) Is licensed and in good standing to offer health insurance
595 coverage in the state;

596 (B) Agrees to offer at least (i) one qualified health plan at a bronze,
597 silver, gold and platinum level of coverage, as determined pursuant to
598 subdivision (7) of section 6 of this act, and (ii) one catastrophic plan,
599 defined in Section 1302(e) of the federal act;

600 (C) Agrees to offer an identical plan outside the exchange, at the
601 same premium rate;

602 (D) Charges the same premium rate for each qualified health plan
603 without regard to whether the plan is offered through the exchange or
604 directly by the health carrier or through an insurance producer;

605 (E) Does not charge any cancellation fees or penalties as set forth in
606 subsection (c) of section 8 of this act;

607 (F) Ensures that commissions or financial incentives paid to an
608 insurance producer or broker in connection with the sale of an
609 insurance plan are comparable irrespective of whether the insurance
610 plan is sold on or outside of the exchange; and

611 (G) Complies with the regulations developed by the Secretary under
612 Section 1311(d) of the federal act and such other requirements as the
613 exchange may establish;

614 (6) The plan meets the requirements for certification pursuant to
615 written procedures adopted under section 3 of this act and regulations
616 promulgated by the Secretary under Section 1311(c) of the federal act;
617 and

618 (7) The exchange determines that making the plan available through
619 the exchange is in the interest of qualified individuals and qualified
620 employers in the state.

621 (b) The exchange shall not refuse to certify a health benefit plan as a
622 qualified health plan:

623 (1) On the basis that (A) the plan is a fee-for-service plan, or (B) the
624 health benefit plan provides treatments necessary to prevent patients'
625 deaths in circumstances the exchange determines are inappropriate or
626 too costly; or

627 (2) By conditioning such certification on the imposition of premium
628 price controls by the exchange.

629 (c) The exchange shall require each health carrier seeking
630 certification of a health benefit plan as a qualified health plan to:

631 (1) Agree to submit a justification for any premium increase before
632 implementation of such increase. The health carrier shall prominently
633 post such justification and any information related to such justification
634 on its Internet web site. The exchange shall take such justification and
635 information into consideration, along with any additional information
636 and recommendations provided to the exchange by the commissioner
637 under Section 2794(b) of the Public Health Service Act, 42 USC 300gg-
638 94, as amended from time to time, when determining whether to allow
639 the health carrier to continue to make such plan available through the
640 exchange;

641 (2) Make available to the public in plain language, as that term is
642 defined in Section 1311(e)(3)(B) of the federal act, and submit to the
643 exchange, the Secretary and the commissioner, accurate and timely
644 disclosure of the following for such plan:

645 (A) Claims payment policies and practices;

646 (B) Periodic financial disclosures;

647 (C) Data on enrollment;

648 (D) Data on disenrollment;

649 (E) Data on the number of claims that are denied;

650 (F) Data on rating practices;

651 (G) Information on cost-sharing and payments with respect to any
652 out-of-network coverage;

653 (H) Information on enrollee and participant rights under Title I of
654 the federal act; and

655 (I) Other information determined as appropriate by the Secretary;
656 and

657 (3) Permit individuals to learn, in a timely manner upon the request
658 of the individual, the amount of cost-sharing, including deductibles,
659 copayments and coinsurance, under the individual's plan or coverage
660 that such individual would be responsible for paying with respect to
661 the furnishing of a specific item or service by a participating provider.
662 At a minimum, this information shall be made available to the
663 individual through an Internet web site and through other means for
664 individuals without access to the Internet.

665 (d) The exchange shall not exempt any health carrier seeking
666 certification of a health benefit plan as a qualified health plan from
667 state licensure or reserve requirements and shall apply the criteria of
668 this section in a manner that assures a level playing field between or
669 among health carriers participating in the exchange.

670 (e) (1) The provisions of sections 1 to 13, inclusive, of this act, that
671 are applicable to qualified health plans, shall also apply to the extent
672 applicable to qualified dental plans, except as modified in accordance
673 with the provisions of subdivisions (2), (3) and (4) of this subsection or
674 by written procedures adopted by the exchange.

675 (2) A health carrier seeking certification of a dental benefit plan as a
676 qualified dental plan shall be licensed in the state to offer dental
677 coverage, but need not be licensed to offer other health benefits.

678 (3) Qualified dental plans shall be limited to dental and oral health
679 benefits, without substantial duplication of the benefits typically

680 offered by health benefit plans without dental coverage and shall
681 include, at a minimum, the essential pediatric dental benefits
682 prescribed by the Secretary pursuant to Section 1302(b)(1)(J) of the
683 federal act, and such other dental benefits as the exchange may specify
684 or the Secretary may specify by regulation.

685 (4) Health carriers may jointly offer a comprehensive plan through
686 the exchange in which dental benefits are provided by a health carrier
687 through a qualified dental plan and health benefits are provided by
688 another health carrier through a qualified health plan, provided the
689 plans are priced separately and are also made available for purchase
690 separately at the same such prices.

691 Sec. 10. (NEW) (*Effective from passage*) The state of Connecticut does
692 hereby pledge to, and agree with, any person with whom the exchange
693 may enter into contracts pursuant to the provisions of sections 1 to 13,
694 inclusive, of this act, that the state will not limit or alter the rights
695 hereby vested in the exchange until such contracts and the obligations
696 thereunder are fully met and performed on the part of the exchange,
697 except that nothing in this section shall preclude such limitation or
698 alteration if adequate provision shall be made by law for the protection
699 of such persons entering into contracts with the exchange.

700 Sec. 11. (NEW) (*Effective from passage*) The exchange shall be exempt
701 from all franchise, corporate business, property and income taxes
702 levied by the state or any municipality, except that nothing in this
703 section shall be construed to exempt from any such taxes, or from any
704 taxes levied in connection with, (1) the manufacture or sale of any
705 products that are the subject of any agreement made by the exchange,
706 or (2) any person entering into any contract with the exchange.

707 Sec. 12. (NEW) (*Effective from passage*) (a) Not later than January 1,
708 2013, the board of directors of the exchange shall report, in accordance
709 with section 11-4a of the general statutes, to the Governor and the joint
710 standing committees of the General Assembly having cognizance of
711 matters relating to finance, revenue and bonding, insurance and public
712 health on the following:

713 (1) The potential effect of adverse selection on the operations of the
714 exchange and recommendations to reduce the potential negative
715 impact from any such adverse selection, including, but not limited to:

716 (A) Recommendations to ensure that rules governing health benefit
717 plans are similar for plans offered through the exchange and outside
718 the exchange; and

719 (B) Recommendations on whether the exchange should, as a
720 condition of participating in the exchange:

721 (i) Require health carriers to offer health benefit plans such carriers
722 offer outside the exchange at silver and gold levels of coverage, as
723 determined pursuant to subdivision (7) of section 6 of this act; and

724 (ii) Prohibit such carriers from only offering health benefit plans at a
725 bronze level of coverage, as determined pursuant to subdivision (7) of
726 section 6 of this act, and catastrophic plans, as defined in Section
727 1302(e) of the federal act, outside the exchange; or

728 (iii) Prohibit health carriers from offering through or outside the
729 exchange, through affiliates, the same health benefit plans at different
730 premium rates;

731 (2) Recommendations to promote transparency in the exchange
732 including, but not limited to, whether any contract between a health
733 carrier and the exchange should be subject to disclosure pursuant to
734 section 1-210 of the general statutes;

735 (3) (A) An initial methodology for imposing assessments or user
736 fees on health carriers that demonstrates a reasonable likelihood of (i)
737 collecting sufficient funds for the exchange including start-up costs,
738 operating and administrative costs and moneys for navigator awards
739 under section 7 of this act, and (ii) achieving financial sustainability of
740 the exchange on or before January 1, 2015; and

741 (B) Any other funds the exchange has procured or is attempting to
742 procure;

743 (4) Recommendations to ensure maximum participation by
744 individuals and small employers in the exchange in order to optimally
745 pool risks;

746 (5) Recommendations to ensure that the exchange is a viable and
747 competitive alternative in the procurement of a health benefit plan for
748 individuals and small employers;

749 (6) Recommendations to ensure that the administrative costs
750 relating to the procurement of a health benefit plan for small
751 employers participating in the exchange are reduced;

752 (7) Recommendations to ensure that defined contributions from a
753 qualified employer for an employee's procurement of a health benefit
754 plan are in fact used by the employee for the procurement of a health
755 benefit plan;

756 (8) Whether to revise the definition of "small employer" from not
757 more than fifty employees to not more than one hundred employees;

758 (9) Whether to allow employers with more than one hundred
759 employees to participate in the exchange beginning in 2017;

760 (10) Whether to continue to require qualified health plans to provide
761 benefits beyond those that are to be included in the essential health
762 benefits package, as described in Section 1302(a) of the federal act;

763 (11) The administrative role, if any, the exchange should have in the
764 collection and payment of premiums due to health carriers from
765 individuals and small employers purchasing health benefit plans on
766 the exchange;

767 (12) The relationship of the exchange to insurance producers and
768 agents;

769 (13) Recommendations to ensure that transitions between state
770 health care programs, including, Medicaid, HUSKY Plan, Part A or
771 Part B, and the Charter Oak Health Plan, other federally subsidized

772 health care coverage and fully private pay health coverage are
773 centralized, seamless and preserve continuity of coverage and care;
774 and

775 (14) The capacity of the exchange to award navigator grants
776 pursuant to section 7 of this act.

777 (b) (1) The board of directors shall file the initial assessment
778 methodology required under subparagraph (A) of subdivision (3) of
779 subsection (a) of this section with the clerks of the House of
780 Representatives and the Senate not later than ten days after the date on
781 which the report required under subsection (a) of this section has been
782 provided to the Governor and the joint standing committees of the
783 General Assembly having cognizance of matters relating to finance,
784 revenue and bonding, insurance and public health. Such methodology
785 shall be deemed approved if the General Assembly fails to vote to
786 approve or reject such methodology not later than thirty days after the
787 date of filing. If the General Assembly votes to reject such
788 methodology not later than thirty days after the date of filing, the
789 board of directors shall, not later than fifteen days after such rejection,
790 refile a revised methodology. Such refiling shall be subject to the
791 provisions of this subdivision.

792 (2) The provisions of subdivision (1) of this subsection shall apply
793 only to the initial assessment methodology. Any subsequent revision
794 of the initially approved assessment methodology shall not be subject
795 to the provisions of subdivision (1) of this subsection, provided the
796 board of directors shall provide reasonable notice to carriers of any
797 such revision.

798 (c) Not later than one year following the date of implementation of
799 the exchange, and annually thereafter, the board shall evaluate and
800 report to the Governor and the joint standing committees of the
801 General Assembly having cognizance of matters relating to finance,
802 revenue and bonding, insurance and public health whether adverse
803 selection is occurring in the exchange with respect to self-insured plans
804 and health benefit plans offered outside the exchange.

805 Sec. 13. (NEW) (*Effective from passage*) Nothing in sections 1 to 12,
806 inclusive, of this act, and no action taken by the exchange pursuant to
807 said sections of this act shall be construed to preempt or supersede the
808 authority of the commissioner to regulate the business of insurance in
809 the state. Except as expressly provided to the contrary in sections 1 to
810 12, inclusive, of this act, all health carriers offering qualified health
811 plans in the state shall comply with all applicable health insurance
812 laws of the state and regulations adopted and orders issued by the
813 commissioner.

814 Sec. 14. Subsection (l) of section 1-79 of the general statutes is
815 repealed and the following is substituted in lieu thereof (*Effective from*
816 *passage*):

817 (l) "Quasi-public agency" means the Connecticut Development
818 Authority, Connecticut Innovations, Incorporated, Connecticut Health
819 and Education Facilities Authority, Connecticut Higher Education
820 Supplemental Loan Authority, Connecticut Housing Finance
821 Authority, Connecticut Housing Authority, Connecticut Resources
822 Recovery Authority, Lower Fairfield County Convention Center
823 Authority, Capital City Economic Development Authority,
824 Connecticut Lottery Corporation, [and] Health Information
825 Technology Exchange of Connecticut and Connecticut Health
826 Insurance Exchange.

827 Sec. 15. Subdivision (1) of section 1-120 of the general statutes is
828 repealed and the following is substituted in lieu thereof (*Effective from*
829 *passage*):

830 (1) "Quasi-public agency" means the Connecticut Development
831 Authority, Connecticut Innovations, Incorporated, Connecticut Health
832 and Educational Facilities Authority, Connecticut Higher Education
833 Supplemental Loan Authority, Connecticut Housing Finance
834 Authority, Connecticut Housing Authority, Connecticut Resources
835 Recovery Authority, Capital City Economic Development Authority,
836 Connecticut Lottery Corporation, [and] Health Information
837 Technology Exchange of Connecticut and Connecticut Health

838 Insurance Exchange.

839 Sec. 16. Section 1-124 of the general statutes is repealed and the
840 following is substituted in lieu thereof (*Effective from passage*):

841 (a) The Connecticut Development Authority, the Connecticut
842 Health and Educational Facilities Authority, the Connecticut Higher
843 Education Supplemental Loan Authority, the Connecticut Housing
844 Finance Authority, the Connecticut Housing Authority, the
845 Connecticut Resources Recovery Authority, the Health Information
846 Technology Exchange of Connecticut, [and] the Capital City Economic
847 Development Authority and the Connecticut Health Insurance
848 Exchange shall not borrow any money or issue any bonds or notes
849 which are guaranteed by the state of Connecticut or for which there is
850 a capital reserve fund of any kind which is in any way contributed to
851 or guaranteed by the state of Connecticut until and unless such
852 borrowing or issuance is approved by the State Treasurer or the
853 Deputy State Treasurer appointed pursuant to section 3-12. The
854 approval of the State Treasurer or said deputy shall be based on
855 documentation provided by the authority that it has sufficient
856 revenues to (1) pay the principal of and interest on the bonds and notes
857 issued, (2) establish, increase and maintain any reserves deemed by the
858 authority to be advisable to secure the payment of the principal of and
859 interest on such bonds and notes, (3) pay the cost of maintaining,
860 servicing and properly insuring the purpose for which the proceeds of
861 the bonds and notes have been issued, if applicable, and (4) pay such
862 other costs as may be required.

863 (b) To the extent the Connecticut Development Authority,
864 Connecticut Innovations, Incorporated, Connecticut Higher Education
865 Supplemental Loan Authority, Connecticut Housing Finance
866 Authority, Connecticut Housing Authority, Connecticut Resources
867 Recovery Authority, Connecticut Health and Educational Facilities
868 Authority, the Health Information Technology Exchange of
869 Connecticut, [or] the Capital City Economic Development Authority or
870 the Connecticut Health Insurance Exchange is permitted by statute and

871 determines to exercise any power to moderate interest rate fluctuations
872 or enter into any investment or program of investment or contract
873 respecting interest rates, currency, cash flow or other similar
874 agreement, including, but not limited to, interest rate or currency swap
875 agreements, the effect of which is to subject a capital reserve fund
876 which is in any way contributed to or guaranteed by the state of
877 Connecticut, to potential liability, such determination shall not be
878 effective until and unless the State Treasurer or his or her deputy
879 appointed pursuant to section 3-12 has approved such agreement or
880 agreements. The approval of the State Treasurer or his or her deputy
881 shall be based on documentation provided by the authority that it has
882 sufficient revenues to meet the financial obligations associated with the
883 agreement or agreements.

884 Sec. 17. Section 1-125 of the general statutes is repealed and the
885 following is substituted in lieu thereof (*Effective from passage*):

886 The directors, officers and employees of the Connecticut
887 Development Authority, Connecticut Innovations, Incorporated,
888 Connecticut Higher Education Supplemental Loan Authority,
889 Connecticut Housing Finance Authority, Connecticut Housing
890 Authority, Connecticut Resources Recovery Authority, including ad
891 hoc members of the Connecticut Resources Recovery Authority,
892 Connecticut Health and Educational Facilities Authority, Capital City
893 Economic Development Authority, the Health Information Technology
894 Exchange of Connecticut, [and] Connecticut Lottery Corporation and and
895 Connecticut Health Insurance Exchange and any person executing the
896 bonds or notes of the agency shall not be liable personally on such
897 bonds or notes or be subject to any personal liability or accountability
898 by reason of the issuance thereof, nor shall any director or employee of
899 the agency, including ad hoc members of the Connecticut Resources
900 Recovery Authority, be personally liable for damage or injury, not
901 wanton, reckless, wilful or malicious, caused in the performance of his
902 or her duties and within the scope of his or her employment or
903 appointment as such director, officer or employee, including ad hoc
904 members of the Connecticut Resources Recovery Authority. The

905 agency shall protect, save harmless and indemnify its directors,
 906 officers or employees, including ad hoc members of the Connecticut
 907 Resources Recovery Authority, from financial loss and expense,
 908 including legal fees and costs, if any, arising out of any claim, demand,
 909 suit or judgment by reason of alleged negligence or alleged
 910 deprivation of any person's civil rights or any other act or omission
 911 resulting in damage or injury, if the director, officer or employee,
 912 including ad hoc members of the Connecticut Resources Recovery
 913 Authority, is found to have been acting in the discharge of his or her
 914 duties or within the scope of his or her employment and such act or
 915 omission is found not to have been wanton, reckless, wilful or
 916 malicious.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	New section
Sec. 2	<i>from passage</i>	New section
Sec. 3	<i>from passage</i>	New section
Sec. 4	<i>from passage</i>	New section
Sec. 5	<i>from passage</i>	New section
Sec. 6	<i>from passage</i>	New section
Sec. 7	<i>from passage</i>	New section
Sec. 8	<i>from passage</i>	New section
Sec. 9	<i>from passage</i>	New section
Sec. 10	<i>from passage</i>	New section
Sec. 11	<i>from passage</i>	New section
Sec. 12	<i>from passage</i>	New section
Sec. 13	<i>from passage</i>	New section
Sec. 14	<i>from passage</i>	1-79(l)
Sec. 15	<i>from passage</i>	1-120(1)
Sec. 16	<i>from passage</i>	1-124
Sec. 17	<i>from passage</i>	1-125

APP *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: See below

Municipal Impact: None

Explanation

This bill creates the Connecticut Health Insurance 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 health carriers 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.

The Out Years

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

OLR Bill Analysis**sSB 1204*****AN ACT ESTABLISHING THE CONNECTICUT HEALTH INSURANCE EXCHANGE.*****SUMMARY:**

This bill establishes the Connecticut Health Insurance Exchange, a quasi-public agency, to satisfy requirements of the federal Patient Protection and Affordable Care Act ("PPACA"). Under the bill, a 12-member board manages the exchange, including operating an online marketplace where individuals and small employers (i.e., an employer with up to 50 employees) will be able to compare and purchase insurance plans beginning in 2014.

EFFECTIVE DATE: Upon passage

§§ 2, 14-17 – EXCHANGE CREATION

The bill creates the Connecticut Health Insurance Exchange (exchange) as a quasi-public agency and adds it to the statutes governing quasi-public agencies. It must be a solvent and self-sustaining entity by January 1, 2015. The exchange is not a state department, institution, or agency.

The purpose of the exchange is to reduce the number of people without health insurance in the state, assist small employers with purchasing and administering health insurance by offering easily comparable and understandable health insurance options to individuals and small employers, and enroll individuals in medical assistance programs (See Section 5 below).

Board Membership

The bill vests the exchange's powers in a 12-member board of directors, which includes the public health, insurance, and social

services commissioners; the Office of Policy and Management secretary; and the healthcare advocate, or their designees, as ex-officio, non-voting members. The governor and the legislative leaders must appoint the seven voting members by October 1, 2011. Board members are not compensated but can be reimbursed for their expenses.

Board Members' Terms and Meetings

Appointed board members serve staggered four-year terms. Four are initially appointed for four years, while the governor's and Senate and House minority leaders' appointees initially serve for three years. Subsequent terms begin on October 1st 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 appoint a member by majority vote. Any director who fails to attend three consecutive meetings or 50% of all meetings during a calendar year is deemed to have resigned.

Meetings must be held as specified in bylaws the board adopts and at other times as the chairperson deems necessary.

The board must elect a chairperson every two years from among its members. The chairperson must schedule the board's first meeting by October 1, 2011.

Board Members' Qualifications

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

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

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

Exchange directors and staff members cannot be employed by or affiliated with (1) an insurer, insurance producer or broker, health care provider, health care facility, or health or medical clinic while serving as an exchange director or staff member or (2) a trade association of insurers, insurance producers or brokers, health care providers, health care facilities, or health or medical clinics. Nor can they be health care providers, unless they receive no compensation as a provider 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 and subscribe the state Constitutional oath or affirmation. A record of the oath must be filed in the secretary of the state's office.

Quorum; Transacting Business

Four of the 12 directors constitute a quorum. The board may act by a majority vote at any meeting where there is a quorum. The bill specifies that a board vacancy does not impair the board's authority to exercise its rights and perform its duties. Any actions it takes may be authorized by resolution, which takes effect immediately unless it provides otherwise.

Chief Executive Officer

The bill requires the board to select and appoint a chief executive officer (CEO) who serves at its pleasure and receives compensation the board sets. The CEO administers the exchange's programs and activities in accordance with the board's established policies and objectives. He or she may hire other employees as designated by the board.

Consultation

The bill allows the board to consult with public or private parties it deems necessary or desirable in performing its duties.

Advisory Committees

The bill authorizes the board to create advisory committees it deems necessary to represent key stakeholders, including consumers, small employers, the insurance industry, and health care providers.

§ 3 – 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 either may take effect;
2. hiring, dismissing, promoting, and compensating exchange employees, 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 for board approval of any nonbudgeted expenditure over \$5,000;
4. contracting for financial, legal, bond, underwriting, and other professional services, including a requirement that the exchange solicit proposals at least once every three years for each service it uses;
5. issuing and retiring bonds, bond anticipation notes, and other obligations of the exchange;
6. establishing requirements for certifying qualified health plans, including minimum standards for marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and coverage descriptions, and quality measures for health benefit plan performance; and
7. implementing the bill or other provisions of state law, provided they do not conflict with U.S. Health and Human Services

(HHS) regulations.

§ 4 – AUDIT

The bill requires the board to require that the exchange be annually audited by HHS. It must submit to the Insurance and Real Estate Committee a copy of each audit conducted by HHS or any independent auditing firm within seven days of receiving the audit.

§ 5 – PURPOSES OF THE EXCHANGE

The bill specifies the purposes of the exchange and permits public funds to be spent to carry them out. Under the bill, the exchange can:

1. employ assistants, agents, and other employees as necessary who are exempt from classified service unless they are not managers;
2. engage consultants, attorneys, and other experts as necessary;
3. acquire, own, manage, hold, or dispose of real and personal property and lease, convey, deal, or enter into agreements concerning its property on any terms necessary to carry out these purposes;
4. receive and accept aid or contributions of any type from any source;
5. charge assessments or user fees to health carriers or otherwise generate funds to support exchange operations and navigator grants (see below);
6. obtain insurance against loss of property and other assets;
7. invest funds not needed for immediate use or disbursement in U.S.- or state-issued or -guaranteed obligations and in obligations that are legal investments for savings banks in Connecticut;
8. issue, fund, or refund bonds, notes, and other obligations of the

exchange for any of its corporate purposes and provide for and secure bondholders' rights;

9. borrow money to obtain working capital;
10. account for and audit its funds and those of any entity that receives funds from the exchange;
11. enter into contracts or agreements necessary to perform its duties, including agreements with the departments of Revenue Services, Social Services, Insurance, Labor, and any other state agency;
12. if permitted under its contracts, agree to any termination, modification, forgiveness, or other change of any term of any contractual right, payment, royalty, contract, or agreement; and
13. award grants to navigators (see below).

§ 5 – 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 shared between the exchange and the departments of Social Services, Public Health, Revenue Services, and Insurance, the Comptroller's Office, or any other state agency that is subject to confidentiality agreements under contracts with the exchange.

§ 6 – DUTIES OF THE EXCHANGE

Under the bill, the exchange must:

1. implement procedures for certifying, recertifying, and decertifying health benefit plans as qualified health plans,

- consistent with HHS guidelines;
2. use selective criteria to limit the number of plans offered through the exchange, provided consumers have an adequate selection of plans;
 3. operate a toll-free consumer assistance hotline;
 4. provide for enrollment periods as provided in PPACA;
 5. maintain an Internet website through which people may obtain (a) standardized comparative information on qualified health plans, (b) quality and price rating information developed by HHS for qualified health plans, and (c) transparent, contractually binding information about a qualified health plan's premiums and cost-sharing requirements, including deductibles, copayments, and coinsurance and coverage limitations;
 6. publish on its website the average costs of licensing, regulatory fees, and any other payments the exchange requires and the exchange's administrative costs, including information on amounts lost to waste, fraud, and abuse;
 7. rate each qualified health plan offered through the exchange and determine each plan's level of coverage, in accordance with criteria and regulations developed by HHS;
 8. use a standardized format for presenting health benefit options in the exchange;
 9. determine if an applicant is eligible for Medicaid, the State Children's Health Insurance Program, or other state public programs and enroll an eligible applicant in the program;
 10. establish and make available electronically a calculator that allows individuals to determine the actual cost of coverage, taking into consideration any applicable premium tax credit and

- cost-sharing reduction;
11. ensure a qualified employer is allowed to make defined contributions to a health carrier on behalf of an employee enrolling in a qualified health plan;
 12. certify if an individual is exempt from the PPACA requirement to carry health insurance or from the penalty for not doing so;
 13. provide to the U.S. treasury secretary the name and taxpayer identification number of each individual (a) granted an exemption from PPACA requirements, (b) who was an employee eligible for the premium tax credit because his or her employer did not provide minimum essential health benefits coverage or provided coverage that was unaffordable or did not meet the required actuarial value, (c) who notifies the exchange he or she has changed employers, and (d) who ceases coverage under a qualified health plan during a plan year, and the effective date of that cessation;
 14. give each employer the name of each employee who was eligible for a premium tax credit and ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;
 15. determine eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions as required by HHS or the Treasury department;
 16. select entities qualified to serve as navigators under PPACA and award grants to them (see below);
 17. review the rate of premium growth within and outside the exchange and consider that information when developing recommendations on whether to continue limiting qualified employer status to small employers;
 18. develop ways to independently evaluate consumers'

experiences with the exchange, including hiring consultants to act as “secret shoppers”;

19. establish (a) rating systems that allow individuals and small employers to compare the value of competing qualified health plans and (b) plan member satisfaction surveys that emphasize soliciting comment from members with serious health conditions or financial difficulties resulting from serious health conditions; and
20. credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled and collect the amount credited from the offering employer. (A free choice voucher is an option that allows employees with incomes up to 400% of the federal poverty level (FPL) to apply the amount their employer contributes for insurance to buy a plan on the exchange if the amount they must pay for employer-sponsored insurance is unaffordable.)

Stakeholders

The exchange must consult with stakeholders relevant to implementing the bill, including:

1. people who are knowledgeable about the health care system, have experience in making informed decisions regarding health, medical, and scientific matters, and are enrolled in qualified health plans;
2. people and entities with experience in facilitating enrollment in qualified health plans;
3. representatives of small employers and self-employed individuals;
4. the Department of Social Services (DSS); and
5. advocates for enrolling hard-to-reach populations.

Financial Integrity

The exchange must meet the following financial integrity requirements:

1. keep an accurate accounting of all activities, receipts, and expenditures and annually report about these to HHS and the governor, insurance commissioner, and legislature;
2. fully cooperate with any HHS investigation and allow HHS to (a) investigate its affairs, (b) examine its properties and records, and (c) require periodic reports of its activities; and
3. ensure that its funds are not spent for staff retreats, promotional giveaways, excessive executive compensation, or lobbying state or federal governments.

§ 7 – NAVIGATOR GRANT PROGRAM

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

Under the bill, a navigator must:

1. conduct public education activities to raise awareness of 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 federal premium tax credits and cost-sharing reductions under 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 manner that is culturally and linguistically appropriate.

Entities Allowed as Navigators

The bill requires the exchange 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. a Connecticut-licensed insurance producer or broker.

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

To receive a navigator award, an entity must demonstrate to the board’s satisfaction that it has (1) relationships, or could develop relationships, with small employers, their employees, and individuals, including those who are underinsured, uninsured, or self-insured, who are likely to qualify to enroll in a qualified health plan or (2) particular expertise or experience in meeting the health insurance needs of small employers, minorities, seniors, and young adults.

Compliance and Standards

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

§§ 8, 9 – QUALIFIED HEALTH PLANS

The bill requires the exchange to make qualified health plans

available to qualified individuals and employers by January 1, 2014. The exchange cannot make plans available unless they are qualified health plans.

The bill defines a “qualified health plan” as a health benefit plan that is certified as meeting criteria outlined in PPACA and this bill. A “qualified individual” is a state resident seeking to enroll in a qualified health plan offered to individuals through the exchange. A “qualified employer” is a small employer that elects to make its full-time employees eligible for at least one qualified health plan offered through the exchange, and if it chooses, make some or all part-time employees eligible. The employer must either (1) have its principal place of business in Connecticut and provide coverage through the exchange to all its eligible employees wherever located or (2) provide coverage through the exchange to all its eligible employees employed in Connecticut.

The exchange must allow a health carrier to offer a limited scope dental plan, either separately or as part of a plan that covers pediatric dental benefits.

Under the bill, the exchange or a health carrier offering plans through the exchange cannot charge a coverage termination fee or penalty if an individual enrolls in another type of minimum essential coverage because he or she is newly eligible for the coverage or the individual’s employer-sponsored coverage has become affordable under federal standards.

Employer Requirements

To participate in the exchange, a qualified employer must:

1. not offer to its employees coverage outside the exchange under a competing health benefit plan that offers the same, or substantially the same, benefits provided through the exchange;
2. participate in a “cafeteria plan” that allows employees to get federal tax benefits for their health insurance premium

payments; and

3. make available in a timely manner, for confidential review by the exchange's CEO, employer documents, records, or other information the CEO determines are necessary to verify (a) that the employer is complying with state and federal law relating to providing group health plans, especially nondiscrimination in coverage, and (b) enrollees' eligibility under the health benefit plan's terms.

The bill also requires the employer to reserve the right to determine, subject to state and federal law, employer eligibility, enrollment, and participation criteria, and the amount of any employer contributions to a qualified health plan to cover its employees. (It appears to give the employer the responsibility to determine its own eligibility to participate in the exchange but requires the exchange to determine whether the employer is allowed to make defined contributions to a health carrier on behalf of an employee enrolling in a qualified health plan.)

Certifying Qualified Health Plans

The bill authorizes the exchange to certify a health benefit plan as a qualified health plan if:

1. the plan covers the state's insurance benefit mandates and the federally designated essential health benefits (but a plan does not have to contain all essential health benefits if it is a qualified dental plan and the health carrier prominently discloses that (a) the plan does not provide all essential pediatric benefits and (b) qualified dental plans with those and other dental benefits are offered through the exchange);
2. the insurance commissioner has approved the premium rates and contract language;
3. the plan provides at least a bronze level of coverage (covering 60% of the cost of essential health benefits) unless it is certified

as meeting federal catastrophic plan requirements and is offered only to people eligible for such plans (e.g., under age 30 or exempt from PPACA's requirement to carry health insurance);

4. the plan complies with federal limits on out-of-pocket costs;
5. the plan meets the requirements for certification in accordance with the exchange's adopted written procedures and HHS regulations; and
6. the exchange determines that making the plan available is in the interests of qualified individuals and employers in the state.

Under the bill, the exchange cannot refuse to certify a plan (1) because it is a fee-for-service plan, (2) by imposing premium price controls, or (3) because it provides treatments to prevent patients' deaths in circumstances the exchange believes are too costly or inappropriate.

The exchange cannot exempt any health carrier from state licensure or reserve requirements and must apply the certification criteria in a way that assures a level playing field among health carriers participating in the exchange.

Health Carrier Requirements

To be eligible to offer qualified health plans through the exchange, a health carrier must:

1. be licensed and in good standing to offer health insurance in Connecticut;
2. offer through the exchange one catastrophic plan and at least one plan each at the (a) bronze coverage level (covering 60% of the cost of essential health benefits), (b) silver coverage level (covering 70% of this cost), (c) gold coverage level (covering 80% of this cost), and (d) platinum coverage level (covering 90% of this cost);

3. offer an identical plan outside the exchange at the same premium rate (presumably for each of the five plans above);
4. charge the same premium rate for each qualified health plan whether offered (a) through the exchange or outside the exchange or (b) directly by the carrier or through an insurance producer;
5. not charge a coverage termination fee or penalty to an individual who enrolls in another type of minimum essential coverage because he or she is newly eligible for the coverage or the individual's employer-sponsored coverage has become affordable under federal standards;
6. ensure that commissions or financial incentives paid to an insurance producer or broker in connection with an insurance plan's sale are comparable whether the plan is sold within or outside the exchange; and
7. comply with HHS regulations and any other requirements the exchange may establish.

A health carrier seeking exchange certification for a qualified health plan must agree to submit (presumably to the exchange) and prominently post on the carrier's website, justification for any premium increase (and any related information) before it is implemented (the bill does not give a specific timeframe). The exchange must consider this justification, along with any additional information and recommendations from the insurance commissioner, when determining whether to allow the carrier to continue making the plan available through the exchange.

A health carrier must disclose information to the public in plain language regarding claims, finances, enrollment and disenrollment, rating practices, out-of-network payments and cost sharing, enrollee rights under PPACA, and other information HHS requires. It must also submit this information to the exchange, insurance commissioner and

HHS.

A health carrier must also 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. The information must be provided through an Internet website and through other means (which the bill does not specify) for individuals without Internet access.

Qualified Dental Plans

The bill applies, to the extent applicable, to qualified dental plans, except as modified by written procedures adopted by the exchange and the following:

1. a health carrier seeking certification of a dental plan as a qualified dental plan must be licensed in Connecticut to offer dental coverage but does not need to be licensed to offer other health benefits;
2. qualified dental plans are limited to dental and oral health benefits, cannot duplicate benefits typically offered by non-dental plans, and must include, at a minimum, the essential pediatric dental benefits defined by HHS and other dental benefits as the exchange or HHS may specify; and
3. health carriers may jointly offer a comprehensive plan through the exchange in which dental benefits are provided by one carrier and health benefits by another carrier, as long as the plans are priced and made available for purchase separately.

§ 10 – STATE PLEDGE REGARDING CONTRACTUAL OBLIGATIONS

Under the bill, the state pledges and agrees with any person the exchange contracts with that the state will not limit or alter the rights vested in the exchange until the exchange's contractual obligations are fully met and performed. But the bill does not preclude limitation or alteration if the law makes adequate provision to protect those with

contracts with the exchange.

§ 11 – EXCHANGE TAX EXEMPTIONS

The bill exempts the exchange from all state and local franchise, corporate business, property, and income taxes except for those levied for or in connection with (1) the manufacture or sale of products subject to an agreement made by the exchange or (2) any person contracting with the exchange.

§ 12 – REPORTING REQUIREMENTS

The bill requires the exchange's board to report to the governor and Insurance, Public Health and Finance Committees by January 1, 2013 on:

1. the potential effect of adverse selection on the exchange (see below);
2. recommendations to promote transparency in the exchange, including whether contracts between health carriers and the exchange should be subject to disclosure under the Freedom of Information Act;
3. an initial methodology for imposing assessments or user fees on health carriers that are reasonably likely to (a) collect sufficient funds for the exchange, including start-up, operating, and administrative costs, and money for navigator grants and (b) achieve financial sustainability for the exchange by January 1, 2015;
4. any funds the exchange has or is attempting to procure;
5. recommendations to ensure (a) maximum participation in the exchange by individuals and small employers to optimally pool risks, (b) the exchange is a viable and competitive alternative for individuals and small employers to procure health benefit plans, (c) that administrative costs relating to procuring health benefit plans are reduced for small employers participating in

- the exchange, and (d) that an employee uses a qualified employer's defined contributions to purchase a health benefit plan;
6. whether to expand the definition of "small employer" to include employers with up to 100 employees;
 7. whether to allow employers with more than 100 employees to participate in the exchange starting in 2017;
 8. whether to continue to require qualified health plans to provide benefits beyond those included in the federal essential health benefits package;
 9. any administrative role the exchange should have in collecting and paying premiums due health carriers from individuals and small employers purchasing health benefit plans on the exchange;
 10. the relationship of the exchange to insurance producers and agents;
 11. recommendations to ensure that transitions between state health care programs (including Medicaid, HUSKY A and B, and the Charter Oak Plan) and federally subsidized and private pay health care coverage are centralized, seamless, and preserve continuity of coverage and care; and
 12. the exchange's capacity to award navigator grants.

Report on Adverse Selection

The above report must include (1) the effect of adverse selection on the exchange's operation and (2) any recommendations to reduce the potential negative effect of any such adverse selection. The report must include recommendations to ensure that regulation of health benefit plans is similar for qualified health plans offered through the exchange and health benefit plans offered outside it. It must also include recommendations on whether the exchange should require health

carriers, as a condition of participating in the exchange, to (1) offer health benefit plans outside the exchange at silver and gold coverage levels, (2) offer more than just catastrophic or bronze coverage level plans outside the exchange, or (3) not offer within or outside the exchange through affiliates, the same health benefit plans at different premium rates.

Within one year of the exchange's implementation, the board must also start to annually evaluate and report to the governor and Insurance, Public Health, and Finance committees on whether adverse selection is occurring with respect to self-insured plans and plans sold outside the exchange.

Initial Assessment Methodology

The bill requires the exchange's board of directors to file the initial assessment methodology for imposing user fees or assessments required above with the House and Senate clerks within 10 days after the date it submits its initial report to the governor and legislative committees. The methodology is deemed approved if the legislature does not vote to approve or reject it within 30 days of its filing. If the legislature rejects the methodology, the board of directors must refile a revised methodology within 15 days of the vote. It specifies that these requirements apply only to the board's initial assessment methodology as long as the board provides reasonable notice to carriers of any subsequent changes to the approved initial methodology.

§ 13 – INSURANCE COMMISSIONER'S AUTHORITY

The bill and the exchange's actions do not preempt or supersede the insurance commissioner's authority to regulate insurance in Connecticut. Unless the bill expressly provides to the contrary, all health carriers offering qualified health plans in Connecticut must comply with all applicable state health insurance laws and regulations and insurance commissioner's orders.

BACKGROUND

Legislative History

On April 27, the Senate referred the bill (File 526) to the Appropriations Committee, which favorably reported a substitute that eliminated the provisions in the bill establishing a (1) Basic Health Program for certain Medicaid-ineligible adults starting January 1, 2014 and (2) separate non-lapsing “Basic Health Plan Program Account” in the General Fund. It also eliminated the provision requiring DSS, starting January 1, 2014, to provide Medicaid to all adults ages 18 to 64 (1) who qualify for coverage under PPACA’s provisions extending Medicaid to low-income adults and (2) whose family income is up to 133% of the FPL, regardless of assets.

Related Bills

The Insurance and Real Estate Committee favorably reported SB 921 and HB 6323, both of which similarly create an exchange as a quasi-public agency.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
 Yea 18 Nay 10 (03/30/2011)

Appropriations Committee

Joint Favorable Substitute
 Yea 28 Nay 20 (05/04/2011)