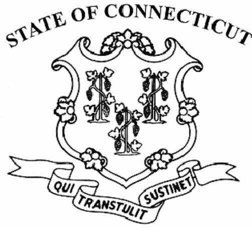

General Assembly **Substitute Bill No. 6323**

January Session, 2011 *____HB06323FIN___040711____*

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

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

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 Section 38a-497 of the general statutes is repealed and the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

3 **[**Every**]** Each individual health insurance policy providing coverage
4 of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12)
5 of section 38a-469 delivered, issued for delivery, amended, renewed or
6 continued in this state shall provide that coverage of a child shall
7 terminate no earlier than the policy anniversary date on or after
8 whichever of the following occurs first, the date on which the child:
9 **[**Marries; ceases to be a resident of the state; becomes**]** Becomes
10 covered under a group health plan through the dependent's own
11 employment; or attains the age of twenty-six. **[**The residency
12 requirement shall not apply to dependent children under nineteen
13 years of age or full-time students attending an accredited institution of
14 higher education.**]** Each such policy shall cover a stepchild on the same
15 basis as a biological child.

16 Sec. 2. Subsections (a) and (b) of section 38a-554 of the general
17 statutes are repealed and the following is substituted in lieu thereof

18 (*Effective from passage*):

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

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

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

42 (2) Upon the death of the employee, continuation of coverage for the
43 covered dependents of such employee for the periods set forth for such
44 event under federal extension requirements established by the
45 Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272,
46 as amended from time to time;

47 (3) Regardless of the employee's or dependent's eligibility for other
48 group insurance, during an employee's absence due to illness or injury,
49 continuation of coverage for such employee and such employee's

50 covered dependents during continuance of such illness or injury or for
51 up to twelve months from the beginning of such absence;

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

59 (5) The coverage of any covered individual shall terminate: (A) As
60 to a child, the plan shall provide the option for said child to continue
61 coverage for the longer of the following periods: (i) At the end of the
62 month following the month in which the child: **[**Marries; ceases to be a
63 resident of the state; becomes**]** <u>Becomes</u> covered under a group health
64 plan through the dependent's own employment; or attains the age of
65 twenty-six. **[**The residency requirement shall not apply to dependent
66 children under nineteen years of age or full-time students attending an
67 accredited institution of higher education.**]** If on the date specified for
68 termination of coverage on a child, the child is **[**unmarried and**]**
69 incapable of self-sustaining employment by reason of mental or
70 physical handicap and chiefly dependent upon the employee for
71 support and maintenance, the coverage on such child shall continue
72 while the plan remains in force and the child remains in such
73 condition, provided proof of such handicap is received by the carrier
74 within thirty-one days of the date on which the child's coverage would
75 have terminated in the absence of such incapacity. The carrier may
76 require subsequent proof of the child's continued incapacity and
77 dependency but not more often than once a year thereafter, or (ii) for
78 the periods set forth for such child under federal extension
79 requirements established by the Consolidated Omnibus Budget
80 Reconciliation Act of 1985, P.L. 99-272, as amended from time to time;
81 (B) as to the employee's spouse, at the end of the month following the
82 month in which a divorce, court-ordered annulment or legal
83 separation is obtained, whichever is earlier, except that the plan shall

84 provide the option for said spouse to continue coverage for the periods
85 set forth for such events under federal extension requirements
86 established by the Consolidated Omnibus Budget Reconciliation Act of
87 1985, P.L. 99-272, as amended from time to time; and (C) as to the
88 employee or dependent who is sixty-five years of age or older, as of
89 midnight of the day preceding such person's eligibility for benefits
90 under Title XVIII of the federal Social Security Act;

91 (6) As to any other event listed as a "qualifying event" in 29 USC
92 1163, as amended from time to time, continuation of coverage for such
93 periods set forth for such event in 29 USC 1162, as amended from time
94 to time, provided such plan may require the individual whose
95 coverage is to be continued to pay up to the percentage of the
96 applicable premium as specified for such event in 29 USC 1162, as
97 amended from time to time.

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

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

113 (a) The Comptroller, with the approval of the Attorney General and
114 of the Insurance Commissioner, shall arrange and procure a group
115 hospitalization and medical and surgical insurance plan or plans for

116 (1) state employees, (2) members of the General Assembly who elect
117 coverage under such plan or plans, (3) participants in an alternate
118 retirement program who meet the service requirements of section
119 5-162 or subsection (a) of section 5-166, (4) anyone receiving benefits
120 under section 5-144 or from any state-sponsored retirement system,
121 except the teachers' retirement system and the municipal employees
122 retirement system, (5) judges of probate and Probate Court employees,
123 (6) the surviving spouse, and any dependent children until they reach
124 the age of **[**eighteen**]** twenty-six, of a state police officer, a member of
125 an organized local police department, a firefighter or a constable who
126 performs criminal law enforcement duties who dies before, on or after
127 June 26, 2003, as the result of injuries received while acting within the
128 scope of such officer's or firefighter's or constable's employment and
129 not as the result of illness or natural causes, and whose surviving
130 spouse and dependent children are not otherwise eligible for a group
131 hospitalization and medical and surgical insurance plan, (7) employees
132 of the Capital City Economic Development Authority established by
133 section 32-601, and (8) the surviving spouse and dependent children of
134 any employee of a municipality who dies on or after October 1, 2000,
135 as the result of injuries received while acting within the scope of such
136 employee's employment and not as the result of illness or natural
137 causes, and whose surviving spouse and dependent children are not
138 otherwise eligible for a group hospitalization and medical and surgical
139 insurance plan. For purposes of this subdivision, "employee" means
140 any regular employee or elective officer receiving pay from a
141 municipality, "municipality" means any town, city, borough, school
142 district, taxing district, fire district, district department of health,
143 probate district, housing authority, regional work force development
144 board established under section 31-3k, flood commission or authority
145 established by special act or regional planning agency. For purposes of
146 subdivision (6) of this subsection, "firefighter" means any person who
147 is regularly employed and paid by any municipality for the purpose of
148 performing firefighting duties for a municipality on average of not less
149 than thirty-five hours per week. The minimum benefits to be provided
150 by such plan or plans shall be substantially equal in value to the

151 benefits that each such employee or member of the General Assembly
152 could secure in such plan or plans on an individual basis on the
153 preceding first day of July. The state shall pay for each such employee
154 and each member of the General Assembly covered by such plan or
155 plans the portion of the premium charged for such member's or
156 employee's individual coverage and seventy per cent of the additional
157 cost of the form of coverage and such amount shall be credited to the
158 total premiums owed by such employee or member of the General
159 Assembly for the form of such member's or employee's coverage under
160 such plan or plans. On and after January 1, 1989, the state shall pay for
161 anyone receiving benefits from any such state-sponsored retirement
162 system one hundred per cent of the portion of the premium charged
163 for such member's or employee's individual coverage and one
164 hundred per cent of any additional cost for the form of coverage. The
165 balance of any premiums payable by an individual employee or by a
166 member of the General Assembly for the form of coverage shall be
167 deducted from the payroll by the State Comptroller. The total
168 premiums payable shall be remitted by the Comptroller to the
169 insurance company or companies or nonprofit organization or
170 organizations providing the coverage. The amount of the state's
171 contribution per employee for a health maintenance organization
172 option shall be equal, in terms of dollars and cents, to the largest
173 amount of the contribution per employee paid for any other option
174 that is available to all eligible state employees included in the health
175 benefits plan, but shall not be required to exceed the amount of the
176 health maintenance organization premium.

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

180 (f) The Comptroller, with the approval of the Attorney General and
181 of the Insurance Commissioner, shall arrange and procure a group
182 hospitalization and medical and surgical insurance plan or plans for
183 any person who adopts a child from the state foster care system, any
184 person who has been a foster parent for the Department of Children

185 and Families for six months or more, a parent in a permanent family
186 residence for six months or more, and any dependent of such adoptive
187 parent, foster parent or parent in a permanent family residence who
188 elects coverage under such plan or plans. The Comptroller may also
189 arrange for inclusion of such person and any such dependent in an
190 existing group hospitalization and medical and surgical insurance plan
191 offered by the state. Any adoptive parent, foster parent or a parent in a
192 permanent family residence and any dependent who elects coverage
193 shall pay one hundred per cent of the premium charged for such
194 coverage directly to the insurer, provided such adoptive parent, foster
195 parent or parent and all such dependents shall be included in such
196 group hospitalization and medical and surgical insurance plan. A
197 person and his dependents electing coverage pursuant to this
198 subsection shall be eligible for such coverage until no longer an
199 adoptive parent, a foster parent or a parent in a permanent family
200 residence. An adoptive parent shall be eligible for such coverage until
201 the adopted child reaches the age of **[**eighteen or, if the child has not
202 completed a secondary education program, until such child reaches
203 the age of twenty-one**]** <u>twenty-six</u>. As used in this section "dependent"
204 means a spouse or natural or adopted child if such child is wholly or
205 partially dependent for support upon the adoptive parent, foster
206 parent or parent in a permanent family residence.

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

210 (b) (1) No group health insurance plan or insurance arrangement
211 shall impose a preexisting conditions provision that excludes coverage
212 for <u>(A) individuals eighteen years of age and younger, or (B)</u> a period
213 beyond twelve months following the insured's effective date of
214 coverage. Any preexisting conditions provision shall only relate to
215 conditions, whether physical or mental, for which medical advice,
216 diagnosis or care or treatment was recommended or received during
217 the six months immediately preceding the effective date of coverage.

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

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

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

232 **[**(a) Except as provided in subsections (b) and (c), minimum**]** (1)
233 Minimum standard benefits shall be benefits, including coverage for
234 catastrophic illness, **[**with a lifetime maximum of one million dollars
235 per individual, for reasonable charges or, when applicable, the
236 allowance agreed upon between a provider and a carrier for charges
237 actually incurred,**]** for the following health care services, rendered to
238 an individual covered by such plan for the diagnosis or treatment of
239 nonoccupational disease or injury: **[**(1)**]** (A) Hospital services; **[**(2)**]** (B)
240 professional services **[**which**]** that are rendered by a physician or, at
241 **[**his**]** the physician's direction, by a registered nurse, other than
242 services for mental or dental conditions; **[**(3)**]** (C) the diagnosis or
243 treatment of mental conditions, in accordance with the minimum
244 requirements established in section 38a-514; **[**(4)**]** (D) legend drugs
245 requiring a prescription of a physician, advanced practice registered
246 nurse or physician assistant; **[**(5)**]** (E) services of a skilled nursing
247 facility for not more than one hundred twenty days in a calendar year,
248 provided such services commence within fourteen days following a
249 confinement of at least three consecutive days in a hospital for the
250 same condition; **[**(6)**]** (F) home health agency services, as defined by the

251 commissioner, up to a maximum of one hundred eighty visits in a
252 calendar year, provided such services commence [within] not later
253 than seven days [following] after confinement in a hospital or skilled
254 nursing facility of at least three consecutive days for the same
255 condition, provided further, in the case of an individual diagnosed by
256 a physician as terminally ill with a prognosis of six months or less to
257 live, such home health agency services may commence irrespective of
258 whether such covered person was so confined or, if such covered
259 person was so confined, irrespective of such seven-day period, and the
260 yearly benefit for medical social services, as hereinafter defined, shall
261 not exceed two hundred dollars. "Medical social services" means
262 services rendered, under the direction of a physician by a qualified
263 social worker holding a master's degree from an accredited school of
264 social work, including, but not limited to, [(A)] (i) assessment of the
265 social, psychological and family problems related to or arising out of
266 such covered person's illness and treatment; [(B)] (ii) appropriate
267 action and utilization of community resources to assist in resolving
268 such problems; [(C)] (iii) participation in the development of treatment
269 for such covered person; [(7)] (G) use of radium or other radioactive
270 materials; [(8)] (H) outpatient chemotherapy for the removal of tumors
271 and treatment of leukemia, including outpatient chemotherapy; [(9)] (I)
272 oxygen; [(10)] (J) anesthetics; [(11)] (K) nondental prosthesis and
273 maxillo-facial prosthesis used to replace any anatomic structure lost
274 during treatment for head and neck tumors or additional appliances
275 essential for the support of such prosthesis; [(12)] (L) rental of durable
276 medical equipment which has no personal use in the absence of the
277 condition for which prescribed; [(13)] (M) diagnostic x-rays and
278 laboratory tests as defined by the commissioner; [(14)] (N) oral surgery
279 for: [(A)] (i) Excision of partially or completely unerupted impacted
280 teeth, or [(B)] (ii) excision of a tooth root without the extraction of the
281 entire tooth; [(15)] (O) services of a licensed physical therapist,
282 rendered under the direction of a physician; [(16)] (P) transportation
283 by a local professional ambulance to the nearest health care institution
284 qualified to treat the illness or injury; [(17)] (Q) certain other services
285 which are medically necessary in the treatment or diagnosis of an

286 illness or injury as may be designated or approved by the Insurance
287 Commissioner; and **[**(18)**]** (R) confinement in a facility established
288 primarily for the treatment of alcoholism and licensed for such care by
289 the state, or in a part of a hospital used primarily for such treatment,
290 **[**shall be a covered expense**]** for a period of at least forty-five days
291 within any calendar year.

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

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

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

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

309 (1) For policies issued or renewed prior to April 1, 1994, subject to
310 the provisions of subdivision (3) of this subsection, such plan may
311 require deductibles. The "low option deductible" shall be two hundred
312 dollars per person, the "middle option deductible" shall be five
313 hundred dollars per person, and the "high option deductible" shall be
314 seven hundred fifty dollars per person. The amount of the deductible
315 may not be greater when a service is rendered on an outpatient basis
316 than when that service is offered on an inpatient basis. Expenses
317 incurred during the last three months of a calendar year and actually

318 applied to an individual's deductible for that year shall be applied to
319 that individual's deductible in the following calendar year. The two-
320 hundred-dollar maximum, the five-hundred-dollar maximum and the
321 seven-hundred-fifty-dollar maximum may be adjusted yearly to
322 correspond with the change in the medical care component of the
323 Consumer Price Index, as adjusted by the commissioner. The base year
324 for such computation shall be the first full year of operation of such
325 plan; **[**.**]**

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

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

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

346 (5) The plan may limit lifetime benefits to a maximum of not less
347 than one million dollars per covered individual.**]**

348 **[**(6)**]** (4) No preexisting condition exclusion shall exclude coverage
349 of any preexisting condition unless **[**: (A) The condition first

350 manifested itself within the period of six months immediately prior to
351 the effective date of coverage in such a manner as would cause a
352 reasonably prudent person to seek diagnosis, care or treatment; (B)
353 medical advice or treatment was recommended or received within the
354 period of six months immediately prior to the effective date of
355 coverage; or (C) the condition is pregnancy existing on**]** <u>such exclusion</u>
356 <u>only relates to conditions, whether physical or mental, for which</u>
357 <u>medical advice, diagnosis or care or treatment was recommended or</u>
358 <u>received during the six months immediately preceding</u> the effective
359 date of coverage. No policy shall exclude coverage for a loss due to
360 preexisting conditions for a period greater than twelve months
361 following the effective date of coverage. Any individual
362 comprehensive health care plan issued as a result of conversion from
363 group health insurance or from a self-insured group shall credit the
364 time covered under such group health insurance toward any such
365 exclusion.

366 (c) Plans providing minimum standard benefits need not provide
367 benefits for the following: (1) Any charge for any care for any injury or
368 disease either (A) arising out of and in the course of an employment
369 subject to a workers' compensation or similar law or where such
370 benefit is required to be provided under a workers' compensation
371 policy to a sole proprietor, business partner or corporation officer who
372 elects such coverage pursuant to the provisions of chapter 568, or (B) to
373 the extent benefits are payable without regard to fault under a
374 coverage statutorily required to be contained in any motor vehicle or
375 other liability insurance policy or equivalent self-insurance; (2) any
376 charge for treatment for cosmetic purposes other than surgery for the
377 prompt repair of an accidental injury sustained while covered,
378 provided cosmetic shall not mean replacement of any anatomic
379 structure removed during treatment of tumors; (3) any charge for
380 travel, other than transportation by local professional ambulance to the
381 nearest health care institution qualified to treat the illness or injury; (4)
382 any charge for private room accommodations to the extent it is in
383 excess of the institution's most common charge for a semiprivate room;

384 (5) any charge by health care institutions to the extent that it is
385 determined by the carrier that the charge exceeds the rates approved
386 by the Office of Health Care Access division of the Department of
387 Public Health; (6) any charge for services or articles to the extent that it
388 exceeds the reasonable charge in the locality for the service; (7) any
389 charge for services or articles [which] that are determined not to be
390 medically necessary, except that this shall not apply to the fabrication
391 or placement of the prosthesis as specified in subparagraph (K) of
392 subdivision [(11)] (1) of subsection (a) of this section and subdivision
393 (2) of this subsection; (8) any charge for services or articles the
394 [provisions] provision of which is not within the scope of the license or
395 certificate of the institution or individual rendering such services or
396 articles; (9) any charge for services or articles furnished, paid for or
397 reimbursed directly by or under any law of a government, except as
398 otherwise provided in this subsection; (10) any charge for services or
399 articles for custodial care or designed primarily to assist an individual
400 in meeting [his] the individual's activities of daily living; (11) any
401 charge for services [which] that would not have been made if no
402 insurance existed or for which the covered individual is not legally
403 obligated to pay; (12) any charge for eyeglasses, contact lenses or
404 hearing aids or the fitting thereof; (13) any charge for dental care not
405 specifically covered by sections 38a-505, 38a-546 and 38a-551 to 38a-
406 559, inclusive; and (14) any charge for services of a registered nurse
407 who ordinarily resides in the covered individual's home, or who is a
408 member of the covered individual's family or the family of the covered
409 individual's spouse.

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

411 (f) The minimum standard benefits of any individual or group
412 comprehensive health care plan may be satisfied by catastrophic
413 coverage offered in conjunction with basic hospital or medical-surgical
414 plans on an expense incurred or service basis as approved by the
415 commissioner as providing at least equivalent benefits.

416 (g) Comprehensive health care plan carriers may offer alternative

417 policy provisions and benefits, including cost containment features,
418 consistent with the purposes of sections 38a-505, 38a-546 and 38a-551
419 to 38a-559, inclusive, provided such alternative provisions and benefits
420 are approved by the Insurance Commissioner prior to their use. Cost
421 containment features may include, but shall not be limited to,
422 preferred provider provisions; utilization review of health care
423 services, including review of the medical necessity of hospital and
424 physician services; case management benefit alternatives; and other
425 managed care provisions.

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

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

442 (j) No comprehensive health care plan issued through the Health
443 Reinsurance Association to a health care tax credit eligible individual
444 shall include any limitation or exclusion of benefit based on a
445 preexisting condition if such individual maintained creditable health
446 insurance coverage for an aggregate period of three months as of the
447 date on which the individual seeks to enroll in the Health Reinsurance
448 Association issued plan, not counting any period prior to a sixty-three-
449 day break in coverage.

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

469 (2) With respect to a group member or dependent who was newly
470 insured under the plan on or after October 1, 2005, and was previously
471 covered under qualifying coverage, but was not covered under such
472 qualifying coverage for a preexisting condition, as defined under the
473 newly issued comprehensive health care plan, such plan shall credit
474 the time such group member or dependent was previously covered by
475 qualifying coverage to the exclusion period of the preexisting
476 condition provision, provided the preceding qualifying coverage was
477 continuous to a date less than one hundred twenty days prior to the
478 effective date of the new coverage, exclusive of any applicable waiting
479 period under such plan, except in the case of a newly insured group
480 member whose preceding qualifying coverage was terminated due to
481 an involuntary loss of employment, the preceding qualifying coverage
482 must have been continuous to a date not more than one hundred fifty
483 days prior to the effective date of the new coverage, exclusive of any

484 applicable waiting period, provided the requirements of this
485 subdivision shall only apply if such newly insured group member or
486 dependent applies for such succeeding coverage not later than thirty
487 days after the first day of the member's or dependent's initial
488 eligibility.

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

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

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

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

513 (b) An insurer or health care center shall apply for approval of such
514 rescission, cancellation or limitation by submitting such written
515 information to the Insurance Commissioner on an application in such

516 form as the commissioner prescribes. Such insurer or health care center
517 shall provide a copy of the application for such approval to the insured
518 or the insured's representative. Not later than seven business days
519 after receipt of the application for such approval, the insured or the
520 insured's representative shall have an opportunity to review such
521 application and respond and submit relevant information to the
522 commissioner with respect to such application. Not later than fifteen
523 business days after the submission of information by the insured or the
524 insured's representative, the commissioner shall issue a written
525 decision on such application. The commissioner **[**may**]** shall only
526 approve: **[**such rescission, cancellation**]**

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

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

545 Sec. 9. Subparagraph (D) of subdivision (1) of section 38a-567 of the
546 general statutes is repealed and the following is substituted in lieu
547 thereof (*Effective from passage*):

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

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

556 (b) The consumer report card shall be known as the "Consumer
557 Report Card on Health Insurance Carriers in Connecticut" and shall
558 include (1) all health care centers licensed pursuant to chapter 698a, (2)
559 the fifteen largest licensed health insurers that use provider networks
560 and that are not included in subdivision (1) of this subsection, (3) the
561 medical loss ratio of each such health care center or licensed health
562 insurer, (4) the information required under subdivision (6) of
563 subsection (a) of section 38a-478c, and (5) information concerning
564 mental health services, as specified in subsection (c) of this section. The
565 insurers selected pursuant to subdivision (2) of this subsection shall be
566 selected on the basis of Connecticut direct written health premiums
567 from such network plans. For the purposes of this section and sections
568 38a-477c, 38a-478c and 38a-478g, "medical loss ratio" **[**means the ratio
569 of incurred claims to earned premiums for the prior calendar year for
570 managed care plans issued in the state. Claims shall be limited to
571 medical expenses for services and supplies provided to enrollees and
572 shall not include expenses for stop loss coverage, reinsurance, enrollee
573 educational programs or other cost containment programs or features**]**
574 has the same meaning as, and shall be calculated in accordance with,
575 the Patient Protection and Affordable Care Act, P.L. 111-148, as
576 amended from time to time, and regulations adopted thereunder.

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

581 (b) Each insurance company, fraternal benefit society, hospital
582 service corporation, medical service corporation and health care center
583 licensed to do business in the state shall comply with Sections 1251,
584 1252 and 1304 of the Affordable Care Act and the following Sections of
585 the Public Health Service Act, as amended by the Affordable Care Act:
586 (1) 2701 to 2709, inclusive, 42 USC 300gg et seq.; (2) 2711 to 2719A,
587 inclusive, 42 USC 300gg-11 et seq.; and (3) 2794, 42 USC 300gg-94.

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

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

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

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

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

602 (2) "Exchange" means the exchange established pursuant to section
603 14 of this act;

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

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

609 (i) Coverage of the type specified in subdivisions (5), (6), (7), (8), (9),

610 (14), (15) and (16) of section 38a-469 of the general statutes or any
611 combination thereof;

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

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

615 (iv) Workers' compensation insurance;

616 (v) Automobile medical payment insurance;

617 (vi) Credit insurance;

618 (vii) Coverage for on-site medical clinics;

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

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

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

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

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

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

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

651 (7) "Small employer" has the same meaning as provided in section
652 38a-564 of the general statutes;

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

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

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

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

669 which public funds may be expended. The exchange shall not be
670 construed to be a department, institution or agency of this state.

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

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

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

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

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

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

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

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

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

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

695 (2) Each appointee, other than the Commissioner of Social Services,
696 shall have demonstrated expertise in at least two of the following

697 areas: (A) Individual health insurance coverage; (B) small employer
698 health insurance coverage; (C) health benefits plan administration; (D)
699 health care finance; (E) public or private health care delivery system
700 administration; or (F) health insurance plan purchase. When making
701 an appointment, the appointing authority shall consider the expertise
702 of the other directors to ensure the board's composition reflects a
703 diversity of expertise and the cultural, ethnic and geographical
704 communities of this state.

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

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

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

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

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

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

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

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

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

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

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

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

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

794 under the provisions of sections 12 to 20, inclusive, of this act or any
795 other provision of the general statutes.

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

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

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

820 (l) The executive director shall supervise the administrative affairs
821 and technical activities of the exchange in accordance with the
822 directives of the board. The executive director shall attend all board
823 meetings and keep a record of the proceedings of the exchange and
824 shall be custodian of all books, documents and papers filed with the
825 exchange, the minute book or journal of the exchange and its official

826 seal. The executive director may give certificates under the official seal
827 of the exchange to the effect that such copies are true copies, and all
828 persons dealing with the exchange may rely upon such certificates.

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

834 (n) The exchange shall be subject to the Freedom of Information Act,
835 as defined in section 1-200 of the general statutes, except that the
836 following information shall not be subject to disclosure under section
837 1-210 of the general statutes: (1) The names and applications of
838 individuals and employers seeking coverage through the exchange; (2)
839 individuals' health information; and (3) information exchanged
840 between the exchange and the (A) Departments of Social Services,
841 Public Health and Revenue Services, (B) Insurance Department, (C)
842 office of the Comptroller, or (D) any other state agency that is subject
843 to confidentiality agreements under contracts entered into pursuant to
844 subdivision (7) of section 15 of this act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

944 (9) Offer individuals and small employers the option of having the
945 exchange collect and administer premiums, including through
946 allocation of premiums among the various insurers and qualified

947 health plans chosen by individual employees;

948 (10) Establish procedures by which individuals and small employers
949 may purchase qualified health plans offered through the exchange
950 through an insurance producer or broker; and

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

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

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

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

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

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

980 (3) Inform consumers of the enrollee satisfaction ratings of a
981 qualified health plan;

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

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

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

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

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

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

999 (10) Enable individuals to apply for and enroll in a health benefit
1000 plan, including medical assistance under Title XIX or XXI of the Social
1001 Security Act, as amended from time to time, through the Internet, by
1002 mail, by phone or in person; and

1003 (11) Refer individuals, where appropriate, to the Office of the
1004 Healthcare Advocate or provide information about health benefit plan
1005 appeals.

1006 (c) The exchange shall use consumer focus groups before it is
1007 operational to ensure its features, such as its Internet web site, works
1008 for consumers, particularly those with low incomes and with special
1009 needs.

1010 (d) The exchange shall establish a standing consumer advisory
1011 committee to provide input to the board of directors of the exchange
1012 on consumer-related matters.

1013 (e) The exchange shall establish methods of independently
1014 evaluating consumers' experience, including, but not limited to, hiring
1015 consultants to act as secret shoppers.

1016 Sec. 17. (NEW) (*Effective from passage*) (a) The exchange shall
1017 establish a Navigator grant program that shall award grants to certain
1018 entities to market the exchange for the purposes of: (1) Conducting
1019 public education activities to raise awareness of the availability of
1020 qualified health plans sold through the exchange; (2) distributing fair
1021 and impartial information concerning enrollment in qualified health
1022 plans; (3) distributing fair and impartial information about the
1023 availability of premium tax credits and cost-sharing reductions
1024 pursuant to the Affordable Care Act; (4) facilitating enrollment in
1025 qualified health plans; (5) referring individuals with a grievance,
1026 complaint or question regarding a plan, a plan's coverage or a
1027 determination under a plan's coverage to the Office of the Healthcare
1028 Advocate or any customer relations unit established by the exchange;
1029 and (6) providing information in a manner that is culturally and
1030 linguistically appropriate to the needs of the population being served
1031 by the exchange.

1032 (b) The exchange shall award Navigator grants, at the sole
1033 discretion of the board of directors, to any of the following entities to
1034 carry out Navigator functions: (1) A trade, industry or professional
1035 association; (2) a community and consumer-focused nonprofit group;
1036 (3) a chamber of commerce; (4) a labor union; (5) a small business
1037 development center; or (6) an insurance producer or broker licensed in

1038 this state. A Navigator shall not be an insurer or receive any
1039 consideration directly or indirectly from any insurer in connection
1040 with the enrollment of any qualified individual or employees of a
1041 qualified employer in a qualified health plan. An eligible entity shall
1042 not receive a Navigator grant unless it can demonstrate to the
1043 satisfaction of the board of directors of the exchange that it has existing
1044 relationships, or could readily establish such relationships, with small
1045 employers and its employees, individuals including uninsured and
1046 underinsured individuals, or self-employed individuals likely to be
1047 qualified to enroll in a qualified health plan.

1048 (c) A Navigator shall comply with all applicable provisions of the
1049 Affordable Care Act, regulations adopted thereunder or federal
1050 guidance issued pursuant to the Affordable Care Act.

1051 (d) The exchange shall collaborate with the Secretary of the United
1052 States Department of Health and Human Services to develop
1053 standards to ensure that the information distributed and provided by
1054 Navigators is fair and accurate.

1055 (e) The exchange shall establish performance standards,
1056 accountability requirements and maximum grant amounts for
1057 Navigators.

1058 Sec. 18. (NEW) (*Effective from passage*) (a) Prior to being eligible to
1059 offer qualified health plans through the exchange, insurers shall be
1060 approved by the exchange in accordance with criteria and procedures
1061 developed by the exchange. Such insurers shall be licensed in this state
1062 and in good standing to offer health insurance coverage in this state.
1063 Any such criteria shall comply with any relevant Affordable Care Act
1064 provision, regulation or guidance. With respect to an insurer seeking
1065 to offer individual qualified health plans, such criteria shall require the
1066 exchange to consider any excess premium growth outside the
1067 exchange as compared to the rate of premium growth of plans offered
1068 through the exchange and information reported by other states with
1069 respect to premium rate growth. In addition, at a minimum, such

1070 criteria shall include requirements that the insurer shall agree to:

1071 (1) To the extent the insurer offers a plan both outside and through
1072 the exchange, offer such plans at the same premium rate;

1073 (2) Offer at least one plan at the silver level of coverage and one plan
1074 at the gold level of coverage, as determined under Section 1311(c)(3) of
1075 the Affordable Care Act, through the exchange;

1076 (3) Make each qualified health plan offered through the exchange
1077 available as a child-only plan at the same coverage level;

1078 (4) Meet marketing standards prescribed by the exchange or the
1079 Affordable Care Act and not use practices or benefit designs that
1080 discourage enrollment of individuals with significant health needs;

1081 (5) Meet specified quality, quality improvement and accreditation
1082 standards;

1083 (6) Meet transparency standards, including disclosure of
1084 information in plain language of: (A) Claims payment policies and
1085 practices; (B) periodic financial disclosures; (C) data on enrollment; (D)
1086 data on disenrollment; (E) data on the number of claims denied; (F)
1087 data on rating practices; (G) information on cost-sharing and payments
1088 with respect to any out-of-network coverage; (H) information on
1089 enrollee and participant rights under Title I of the Affordable Care Act;
1090 and (I) other information as required by the Secretary of the United
1091 States Department of Health and Human Services;

1092 (7) Receive accreditation within the time period set by the United
1093 States Department of Health and Human Services for local
1094 performance on clinical quality measures;

1095 (8) Implement a quality improvement plan that provides incentives
1096 for improving enrollees' health outcomes, preventing hospital
1097 readmissions, improving patient safety and reducing medical errors,
1098 and implement wellness and health promotion activities;

1099 (9) Use a uniform enrollment form approved by the United States
1100 Department of Health and Human Services;

1101 (10) Use a standard format developed by the United States
1102 Department of Health and Human Service for presenting health
1103 benefit plan options;

1104 (11) Provide enrollees and the exchange with information regarding
1105 any quality measures for health plan performance endorsed under
1106 Section 399JJ of the Public Health Service Act, as amended from time to
1107 time;

1108 (12) Permit individuals to learn, in a timely manner, upon request,
1109 the amount of cost-sharing, including, but not limited to, deductibles,
1110 copayments and coinsurance, under the individual's plan or coverage
1111 that the individual would be responsible for paying with respect to the
1112 furnishing of a specific item or service by a participating provider. At a
1113 minimum, this information shall be made available to the individual
1114 through an Internet web site and through other means for individuals
1115 without access to the Internet;

1116 (13) Offer a dental-only plan only if the plan also covers pediatric
1117 dental benefits described in Section 1302(b)(1)(J) of the Affordable Care
1118 Act;

1119 (14) Submit to the exchange a justification for any premium increase
1120 prior to the implementation of such increase. The insurer shall
1121 prominently post such justification on its Internet web site;

1122 (15) Comply with any regulations relating to the duties of the
1123 exchange promulgated by the Secretary of the United States
1124 Department of Health and Human Services pursuant to Section
1125 1311(d) of the Affordable Care Act; and

1126 (16) Comply with any other requirements the exchange may
1127 establish.

1128 (b) The exchange shall not offer a health benefit plan through the

1129 exchange without first certifying that such plan has met the eligibility
1130 requirements set forth in the Affordable Care Act, this section and any
1131 criteria developed by the exchange. Such criteria shall comply with
1132 any relevant Affordable Care Act provision, regulation or guidance
1133 and, at a minimum, shall include requirements that a qualified health
1134 plan shall:

1135 (1) Include, at a minimum, essential benefits as determined under
1136 the Affordable Care Act and the coverage mandates required under
1137 chapter 700c of the general statutes;

1138 (2) Provide emergency department services without prior
1139 authorization or any coverage limit on out-of-network emergency
1140 department service providers;

1141 (3) Provide any out-of-network emergency department coverage
1142 under the same conditions as in-network cost sharing;

1143 (4) Comply with any Affordable Care Act provisions that set out-of-
1144 pocket cost limits;

1145 (5) Meet level of coverage requirements set forth in Section
1146 1302(a)(3) of the Affordable Care Act;

1147 (6) Have an adequate number of providers in the plan's network,
1148 including providers that serve predominantly low-income, medically
1149 underserved individuals, and provide individuals with information
1150 about the availability of in-network and out-of-network providers,
1151 where applicable; and

1152 (7) Meet standards set by the exchange regarding premium rates
1153 and contract language.

1154 (c) Prior to certifying any health benefit plan, the exchange shall
1155 make a determination that making such plan available through the
1156 exchange is in the interests of individuals and small employers.

1157 (d) The exchange shall ensure that a plan is not excluded from the

1158 exchange (1) on the basis that it is a fee-for-service plan, (2) by
1159 imposing premium price controls, or (3) on the basis that it provides
1160 costly benefits, or benefits the exchange believes are inappropriate, to
1161 prevent an enrollee's death.

1162 (e) The exchange may certify catastrophic plans, as defined in
1163 Section 1302(e) of the Affordable Care Act, as qualified benefit plans
1164 for individuals under thirty years of age or who are exempt from the
1165 individual responsibility requirement under the Affordable Care Act.

1166 Sec. 19. (NEW) (*Effective from passage*) To promote transparency in
1167 the operations and administration of the exchange, the exchange shall:

1168 (1) Consult with stakeholders, including individuals who are
1169 knowledgeable about the health care system and have backgrounds or
1170 experience in making informed decisions regarding health, medical
1171 and scientific matters, individuals with experience in health plan
1172 enrollment, small employers and self-employed individuals, state
1173 Medicaid officials and advocates with experience in enrolling hard-to-
1174 reach populations in public assistance programs, relating to exchange
1175 requirements;

1176 (2) Publish on its Internet web site the average costs of licensing,
1177 regulatory fees and any other payments required by the exchange and
1178 the exchange's administrative costs including funds lost to waste,
1179 fraud and abuse;

1180 (3) Keep an accurate accounting of all activity receipts;

1181 (4) Undergo an annual audit by the United States Department of
1182 Health and Human Services;

1183 (5) Fully cooperate with any investigation conducted by the
1184 Secretary of the United States Department of Health and Human
1185 Services or the Inspector General of said department; and

1186 (6) Ensure that its funds are not spent for staff retreats, promotional
1187 giveaways, excessive executive compensation or state or federal

1188 lobbying.

1189 Sec. 20. (NEW) (*Effective from passage*) (a) The exchange shall
1190 coordinate with federal and state agencies and small employers to
1191 verify information relating to individuals and small employers with
1192 regard to an individual's eligibility for a premium tax credit or cost-
1193 sharing reduction by:

1194 (1) Transferring to the Secretary of the Treasury of the United States
1195 a list of (A) individuals who are exempt from the individual
1196 responsibility requirement, including such individual's Social Security
1197 number, (B) individuals who are employed but eligible for the
1198 premium tax credit because the individual's employer did not provide
1199 minimum essential coverage, the individual could not afford such
1200 employer's health benefit plan or the employer did not provide at least
1201 a bronze level of coverage, as determined under Section 1311(c)(3) of
1202 the Affordable Care Act, (C) the name and Social Security number of
1203 each employee who notifies the exchange that such individual has
1204 changed employers, and (D) each individual who ceases coverage
1205 under a qualified health plan during a plan year and the effective date
1206 of such cessation;

1207 (2) Providing to each employer the name of each employee who
1208 qualified for a premium tax credit; and

1209 (3) Providing to the Secretary of the United States Department of
1210 Health and Human Services information on all exchange applicants for
1211 verification of eligibility of such applicants to seek coverage through
1212 the exchange. Such information shall include: (A) For all applicants,
1213 their names, birth dates and citizenship statuses; (B) for applicants
1214 seeking a premium tax credit or cost-sharing reduction, their incomes,
1215 family sizes, full-time employment status and reasons for not being
1216 covered by an employer-sponsored health benefit plan; and (C) for
1217 applicants seeking an exemption from the individual responsibility
1218 requirement under the Affordable Care Act, information supporting
1219 such exemption request.

1220 (b) If the United States Department of Health and Human Services
1221 notifies the exchange that there is an inconsistency in information
1222 provided by an applicant, the exchange shall make a reasonable effort
1223 to identify and address the causes of the inconsistency by contacting
1224 the applicant and by other methods required by said department.

1225 (c) The exchange shall, not later than ninety days after receiving an
1226 application, make determinations on the basis of information the
1227 applicant provides with respect to: (1) The applicant's eligibility for a
1228 premium tax credit and cost-sharing reduction; (2) the affordability of
1229 the applicant's employer's health benefit plan with respect to such
1230 applicant; and (3) the applicant's eligibility for an exemption from the
1231 individual responsibility requirement under the Affordable Care Act.

1232 (d) If there is an unresolved inconsistency in an application with
1233 respect to a premium tax credit or cost-sharing reduction after the
1234 initial ninety-day period, the exchange shall notify the applicant of (1)
1235 the amount, if any, of a premium tax credit or cost-sharing reduction
1236 available to the applicant based on information provided by the United
1237 States Department of Health and Human Services, and (2) available
1238 appeals procedures.

1239 (e) If there is an inconsistency with respect to an application from an
1240 individual seeking an exemption from the individual responsibility
1241 requirement under the Affordable Care Act, the exchange shall, not
1242 later than ninety days after notification is received from the United
1243 States Department of Health and Human Services, notify the
1244 individual (1) that the exchange will not issue a certification of
1245 exemption, and (2) of available appeals procedures.

1246 (f) The exchange shall notify an employer if it receives notification
1247 from the United States Department of Health and Human Services that
1248 the employer may be liable for assessments under the Internal
1249 Revenue Code of 1986, or any subsequent corresponding internal
1250 revenue code of the United States, as amended from time to time,
1251 because the employer failed to provide affordable or minimum

1252 essential coverage through an employer-sponsored plan. The exchange
1253 shall provide the employer with information about available appeals
1254 procedures.

1255 Sec. 21. Subsection (l) of section 1-79 of the general statutes is
1256 repealed and the following is substituted in lieu thereof (*Effective from*
1257 *passage*):

1258 (l) "Quasi-public agency" means the Connecticut Development
1259 Authority, Connecticut Innovations, Incorporated, Connecticut Health
1260 and Education Facilities Authority, Connecticut Higher Education
1261 Supplemental Loan Authority, Connecticut Housing Finance
1262 Authority, Connecticut Housing Authority, Connecticut Resources
1263 Recovery Authority, Lower Fairfield County Convention Center
1264 Authority, Capital City Economic Development Authority,
1265 Connecticut Lottery Corporation, **[**and**]** Health Information
1266 Technology Exchange of Connecticut and Connecticut Health
1267 Partnership Exchange.

1268 Sec. 22. Subdivision (1) of section 1-120 of the general statutes is
1269 repealed and the following is substituted in lieu thereof (*Effective from*
1270 *passage*):

1271 (1) "Quasi-public agency" means the Connecticut Development
1272 Authority, Connecticut Innovations, Incorporated, Connecticut Health
1273 and Educational Facilities Authority, Connecticut Higher Education
1274 Supplemental Loan Authority, Connecticut Housing Finance
1275 Authority, Connecticut Housing Authority, Connecticut Resources
1276 Recovery Authority, Capital City Economic Development Authority,
1277 Connecticut Lottery Corporation, **[**and**]** Health Information
1278 Technology Exchange of Connecticut and Connecticut Health
1279 Partnership Exchange.

1280 Sec. 23. Section 1-124 of the general statutes is repealed and the
1281 following is substituted in lieu thereof (*Effective from passage*):

1282 (a) The Connecticut Development Authority, the Connecticut

1283 Health and Educational Facilities Authority, the Connecticut Higher
1284 Education Supplemental Loan Authority, the Connecticut Housing
1285 Finance Authority, the Connecticut Housing Authority, the
1286 Connecticut Resources Recovery Authority, the Health Information
1287 Technology Exchange of Connecticut, **[**and**]** the Capital City Economic
1288 Development Authority and the Connecticut Health Partnership
1289 Exchange shall not borrow any money or issue any bonds or notes
1290 which are guaranteed by the state of Connecticut or for which there is
1291 a capital reserve fund of any kind which is in any way contributed to
1292 or guaranteed by the state of Connecticut until and unless such
1293 borrowing or issuance is approved by the State Treasurer or the
1294 Deputy State Treasurer appointed pursuant to section 3-12. The
1295 approval of the State Treasurer or said deputy shall be based on
1296 documentation provided by the authority that it has sufficient
1297 revenues to (1) pay the principal of and interest on the bonds and notes
1298 issued, (2) establish, increase and maintain any reserves deemed by the
1299 authority to be advisable to secure the payment of the principal of and
1300 interest on such bonds and notes, (3) pay the cost of maintaining,
1301 servicing and properly insuring the purpose for which the proceeds of
1302 the bonds and notes have been issued, if applicable, and (4) pay such
1303 other costs as may be required.

1304 (b) To the extent the Connecticut Development Authority,
1305 Connecticut Innovations, Incorporated, Connecticut Higher Education
1306 Supplemental Loan Authority, Connecticut Housing Finance
1307 Authority, Connecticut Housing Authority, Connecticut Resources
1308 Recovery Authority, Connecticut Health and Educational Facilities
1309 Authority, the Health Information Technology Exchange of
1310 Connecticut, **[**or**]** the Capital City Economic Development Authority or
1311 the Connecticut Health Partnership Exchange is permitted by statute
1312 and determines to exercise any power to moderate interest rate
1313 fluctuations or enter into any investment or program of investment or
1314 contract respecting interest rates, currency, cash flow or other similar
1315 agreement, including, but not limited to, interest rate or currency swap
1316 agreements, the effect of which is to subject a capital reserve fund

1317 which is in any way contributed to or guaranteed by the state of
1318 Connecticut, to potential liability, such determination shall not be
1319 effective until and unless the State Treasurer or his or her deputy
1320 appointed pursuant to section 3-12 has approved such agreement or
1321 agreements. The approval of the State Treasurer or his or her deputy
1322 shall be based on documentation provided by the authority that it has
1323 sufficient revenues to meet the financial obligations associated with the
1324 agreement or agreements.

1325 Sec. 24. Section 1-125 of the general statutes is repealed and the
1326 following is substituted in lieu thereof (*Effective from passage*):

1327 The directors, officers and employees of the Connecticut
1328 Development Authority, Connecticut Innovations, Incorporated,
1329 Connecticut Higher Education Supplemental Loan Authority,
1330 Connecticut Housing Finance Authority, Connecticut Housing
1331 Authority, Connecticut Resources Recovery Authority, including ad
1332 hoc members of the Connecticut Resources Recovery Authority,
1333 Connecticut Health and Educational Facilities Authority, Capital City
1334 Economic Development Authority, the Health Information Technology
1335 Exchange of Connecticut, [and] Connecticut Lottery Corporation <u>and</u>
1336 <u>Connecticut Health Partnership Exchange</u> and any person executing
1337 the bonds or notes of the agency shall not be liable personally on such
1338 bonds or notes or be subject to any personal liability or accountability
1339 by reason of the issuance thereof, nor shall any director or employee of
1340 the agency, including ad hoc members of the Connecticut Resources
1341 Recovery Authority, be personally liable for damage or injury, not
1342 wanton, reckless, wilful or malicious, caused in the performance of his
1343 or her duties and within the scope of his or her employment or
1344 appointment as such director, officer or employee, including ad hoc
1345 members of the Connecticut Resources Recovery Authority. The
1346 agency shall protect, save harmless and indemnify its directors,
1347 officers or employees, including ad hoc members of the Connecticut
1348 Resources Recovery Authority, from financial loss and expense,
1349 including legal fees and costs, if any, arising out of any claim, demand,
1350 suit or judgment by reason of alleged negligence or alleged

1351 deprivation of any person's civil rights or any other act or omission
1352 resulting in damage or injury, if the director, officer or employee,
1353 including ad hoc members of the Connecticut Resources Recovery
1354 Authority, is found to have been acting in the discharge of his or her
1355 duties or within the scope of his or her employment and such act or
1356 omission is found not to have been wanton, reckless, wilful or
1357 malicious.

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

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

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