



General Assembly

**Substitute Bill No. 1204**

January Session, 2011

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**AN ACT ESTABLISHING THE CONNECTICUT HEALTH INSURANCE EXCHANGE.**

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

1 Section 1. (NEW) (*Effective from passage*) For purposes of this section  
2 and sections 2 to 13, inclusive, of this act:

3 (1) "Board" means the board of directors of the Connecticut Health  
4 Insurance Exchange;

5 (2) "Commissioner" means the Insurance Commissioner;

6 (3) "Exchange" means the Connecticut Health Insurance Exchange  
7 established pursuant to section 2 of this act;

8 (4) "Federal act" means the Patient Protection and Affordable Care  
9 Act, P.L. 111-148, as amended by the Health Care and Education  
10 Reconciliation Act, P.L. 111-152, as both may be amended from time to  
11 time, and regulations adopted thereunder;

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

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

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

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

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

23 (iv) Workers' compensation insurance;

24 (v) Automobile medical payment insurance;

25 (vi) Credit insurance;

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

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

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

35 (i) Limited scope dental or vision benefits;

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

38 (iii) Other similar, limited benefits specified in regulations issued  
39 pursuant to the Health Insurance Portability and Accountability Act of  
40 1996, P.L. 104-191, as amended from time to time;

41 (iv) Other supplemental coverage, similar to coverage of the type  
42 specified in subdivisions (9) and (14) of section 38a-469 of the general

43 statutes, provided under a group health plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

91 (B) For purposes of this subdivision:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

157 (3) Each appointee, other than the commissioners and the secretary,  
158 shall have demonstrated expertise in at least two of the following  
159 areas: (A) Individual health insurance coverage; (B) small employer  
160 health insurance coverage; (C) health benefits plan administration; (D)

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

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

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

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

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

193 Secretary of the State. Meetings of the board of directors shall be held  
194 at such times as shall be specified in the bylaws adopted by the board  
195 and at such other time or times as the chairperson deems necessary.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

316 Revenue Services and Social Services, the Insurance Department, the  
317 Labor Department and any other state agency, as deemed necessary by  
318 the exchange;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

376 (8) Use a standardized format for presenting health benefit options  
377 in the exchange, including the use of the uniform outline of coverage  
378 established under Section 2715 of the Public Health Service Act, 42  
379 USC 300gg-15, as amended from time to time;

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

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

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

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

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

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

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

406 following:

407 (A) A list of the individuals granted a certification under  
408 subdivision (12) of this section, including the name and taxpayer  
409 identification number of each individual;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

455 (D) The Department of Social Services; and

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

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

460 (21) Establish (A) rating systems that permit individuals and small  
461 employers to compare the value of competing qualified health plans;



462 and (B) plan member satisfaction surveys concerning qualified health  
463 plans with particular emphasis on soliciting feedback from plan  
464 members who have serious health conditions or who have  
465 encountered financial difficulties as a result of serious health  
466 conditions; and

467 (22) Meet the following financial integrity requirements:

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

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

476 (i) Investigate the affairs of the exchange;

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

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

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

485 Sec. 7. (NEW) (*Effective from passage*) (a) The exchange shall establish  
486 a navigator grant program that shall award grants to certain entities to  
487 market the exchange for the purposes of: (1) Conducting public  
488 education activities to raise awareness of the availability of qualified  
489 health plans sold through the exchange; (2) distributing fair and  
490 impartial information concerning enrollment in qualified health plans;

491 (3) distributing fair and impartial information about the availability of  
492 premium tax credits and cost-sharing reductions pursuant to the  
493 federal act; (4) facilitating enrollment in qualified health plans; (5)  
494 referring individuals with a grievance, complaint or question  
495 regarding a plan, a plan's coverage or a determination under a plan's  
496 coverage to the Office of the Healthcare Advocate or any customer  
497 relations unit established by the exchange; and (6) providing  
498 information in a manner that is culturally and linguistically  
499 appropriate to the needs of the population being served by the  
500 exchange.

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

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

523 (d) The exchange shall collaborate with the Secretary of the United

524 States Department of Health and Human Services to develop  
525 standards to ensure that the information distributed and provided by  
526 navigators is fair and accurate.

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

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

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

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

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

548 (d) A qualified employer, participating in the exchange: (1) Shall not  
549 offer to its employees outside the exchange coverage under a  
550 competing health benefit plan offering the same, or substantially the  
551 same, benefits provided through the exchange; (2) reserves the right to  
552 determine, subject to applicable state and federal law, (A) employer  
553 criteria for eligibility, enrollment and participation in the exchange,  
554 and (B) the amount of the employer contributions, if any, to a qualified

555 health plan for employee coverage; (3) shall participate in a payroll  
556 deduction program to facilitate the payment of health benefit plan  
557 premium payments by employees to benefit from deductibility of  
558 gross income under 26 USC 125; and (4) shall make available, in a  
559 timely manner, for confidential review by the chief executive officer of  
560 the exchange, employer documents, records or other information that  
561 the chief executive officer reasonably determines are necessary to  
562 verify, (A) that the employer is in compliance with applicable state and  
563 federal law relating to the offering of group health benefit plans,  
564 particularly provisions of such laws relating to nondiscrimination in  
565 coverage, and (B) the eligibility, under the terms of the health benefit  
566 plan, of those employees enrolled in such plan.

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

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

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

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

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

584       (3) The plan provides at least a bronze level of coverage, as  
585 determined pursuant to subdivision (7) of section 6 of this act, unless

586 the plan is certified as a qualified catastrophic plan, meets the  
587 requirements of the federal act for catastrophic plans and will only be  
588 offered to individuals eligible for catastrophic coverage;

589 (4) The plan's cost-sharing requirements do not exceed the limits  
590 established under Section 1302(c)(1) of the federal act, and the plan's  
591 deductibles do not exceed the limits established under Section  
592 1302(c)(2) of the federal act;

593 (5) The health carrier offering the plan:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

644 disclosure of the following for such plan:

645 (A) Claims payment policies and practices;

646 (B) Periodic financial disclosures;

647 (C) Data on enrollment;

648 (D) Data on disenrollment;

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

650 (F) Data on rating practices;

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

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

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

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

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

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

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

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

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

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

700 Sec. 11. (NEW) (*Effective from passage*) The exchange shall be exempt



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

769 (13) Recommendations to ensure that transitions between state  
770 health care programs, including, Medicaid, HUSKY Plan, Part A or  
771 Part B, and the Charter Oak Health Plan, other federally subsidized  
772 health care coverage and fully private pay health coverage are  
773 centralized, seamless and preserve continuity of coverage and care;  
774 and

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

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

791 provisions of this subdivision.

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

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

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

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

817 (l) "Quasi-public agency" means the Connecticut Development  
818 Authority, Connecticut Innovations, Incorporated, Connecticut Health  
819 and Education Facilities Authority, Connecticut Higher Education  
820 Supplemental Loan Authority, Connecticut Housing Finance  
821 Authority, Connecticut Housing Authority, Connecticut Resources

822 Recovery Authority, Lower Fairfield County Convention Center  
823 Authority, Capital City Economic Development Authority,  
824 Connecticut Lottery Corporation, [and] Health Information  
825 Technology Exchange of Connecticut and Connecticut Health  
826 Insurance Exchange.

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

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

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

841 (a) The Connecticut Development Authority, the Connecticut  
842 Health and Educational Facilities Authority, the Connecticut Higher  
843 Education Supplemental Loan Authority, the Connecticut Housing  
844 Finance Authority, the Connecticut Housing Authority, the  
845 Connecticut Resources Recovery Authority, the Health Information  
846 Technology Exchange of Connecticut, [and] the Capital City Economic  
847 Development Authority and the Connecticut Health Insurance  
848 Exchange shall not borrow any money or issue any bonds or notes  
849 which are guaranteed by the state of Connecticut or for which there is  
850 a capital reserve fund of any kind which is in any way contributed to  
851 or guaranteed by the state of Connecticut until and unless such  
852 borrowing or issuance is approved by the State Treasurer or the  
853 Deputy State Treasurer appointed pursuant to section 3-12. The

854 approval of the State Treasurer or said deputy shall be based on  
855 documentation provided by the authority that it has sufficient  
856 revenues to (1) pay the principal of and interest on the bonds and notes  
857 issued, (2) establish, increase and maintain any reserves deemed by the  
858 authority to be advisable to secure the payment of the principal of and  
859 interest on such bonds and notes, (3) pay the cost of maintaining,  
860 servicing and properly insuring the purpose for which the proceeds of  
861 the bonds and notes have been issued, if applicable, and (4) pay such  
862 other costs as may be required.

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

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

886 The directors, officers and employees of the Connecticut

887 Development Authority, Connecticut Innovations, Incorporated,  
 888 Connecticut Higher Education Supplemental Loan Authority,  
 889 Connecticut Housing Finance Authority, Connecticut Housing  
 890 Authority, Connecticut Resources Recovery Authority, including ad  
 891 hoc members of the Connecticut Resources Recovery Authority,  
 892 Connecticut Health and Educational Facilities Authority, Capital City  
 893 Economic Development Authority, the Health Information Technology  
 894 Exchange of Connecticut, [and] Connecticut Lottery Corporation and  
 895 Connecticut Health Insurance Exchange and any person executing the  
 896 bonds or notes of the agency shall not be liable personally on such  
 897 bonds or notes or be subject to any personal liability or accountability  
 898 by reason of the issuance thereof, nor shall any director or employee of  
 899 the agency, including ad hoc members of the Connecticut Resources  
 900 Recovery Authority, be personally liable for damage or injury, not  
 901 wanton, reckless, wilful or malicious, caused in the performance of his  
 902 or her duties and within the scope of his or her employment or  
 903 appointment as such director, officer or employee, including ad hoc  
 904 members of the Connecticut Resources Recovery Authority. The  
 905 agency shall protect, save harmless and indemnify its directors,  
 906 officers or employees, including ad hoc members of the Connecticut  
 907 Resources Recovery Authority, from financial loss and expense,  
 908 including legal fees and costs, if any, arising out of any claim, demand,  
 909 suit or judgment by reason of alleged negligence or alleged  
 910 deprivation of any person's civil rights or any other act or omission  
 911 resulting in damage or injury, if the director, officer or employee,  
 912 including ad hoc members of the Connecticut Resources Recovery  
 913 Authority, is found to have been acting in the discharge of his or her  
 914 duties or within the scope of his or her employment and such act or  
 915 omission is found not to have been wanton, reckless, wilful or  
 916 malicious.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	New section

Sec. 2	<i>from passage</i>	New section
Sec. 3	<i>from passage</i>	New section
Sec. 4	<i>from passage</i>	New section
Sec. 5	<i>from passage</i>	New section
Sec. 6	<i>from passage</i>	New section
Sec. 7	<i>from passage</i>	New section
Sec. 8	<i>from passage</i>	New section
Sec. 9	<i>from passage</i>	New section
Sec. 10	<i>from passage</i>	New section
Sec. 11	<i>from passage</i>	New section
Sec. 12	<i>from passage</i>	New section
Sec. 13	<i>from passage</i>	New section
Sec. 14	<i>from passage</i>	1-79(l)
Sec. 15	<i>from passage</i>	1-120(1)
Sec. 16	<i>from passage</i>	1-124
Sec. 17	<i>from passage</i>	1-125

**APP**      *Joint Favorable Subst.*

**HS**        *Joint Favorable*