



***CONNECTICUT INSURANCE
DEPARTMENT***

LEGISLATIVE SUMMARY

2007

Connecticut Insurance Department 2007 Legislative Summary

Forward

The following public act summaries were written by the Legislative Commissioner's Office and the Office of Legislative Research. Only public acts affecting, or of interest to, the Insurance Department are included in this document. *This document is not intended to convey legal advice on the content of the public acts.*

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Acts Proposed by the Insurance Department

Public Act 07-21 (Senate Bill 1212)

An Act Concerning Coverage by the Connecticut Insurance Guaranty Association (Signed by Governor 5/7/2007)

This act increases the coverage limit for the Connecticut Insurance Guaranty Association from \$300,000 to \$400,000 for claims arising under policies of property and casualty insurers determined insolvent on or after October 1, 2007. By law, the association pays the full amount of workers' compensation claims.

The association, which is funded by assessments against insurers licensed to write property and casualty insurance in Connecticut, is required by law to process and pay qualifying claims filed by state residents against an insolvent insurance company.

EFFECTIVE DATE: October 1, 2007

Public Act 07-113 (Senate Bill 1214)

An Act Concerning Postclaims Underwriting (Signed by the Governor 6/11/2007)

This act prohibits certain health insurers and HMOs from rescinding, canceling, or limiting coverage based on information a person submitted with or omitted from an insurance application if, before issuing the policy, contract, or certificate, the insurer or HMO did not perform a thorough medical underwriting process. This includes resolving all reasonable medical questions based on the written application.

However, the act allows a rescission, cancellation, or limitation based on the application when the insurance commissioner approves it. It requires insurers and HMOs to apply for approval using a process it specifies. It permits the commissioner to approve the action if the enrollee, or the enrollee's representative, knew or should have known that information material to the insurer's or HMO's risk assumption was (1) false when included with the application or (2) omitted from the application. Regardless, it prohibits an insurer or HMO from rescinding, canceling, or limiting any coverage that has been effective for more than two years. The act permits the commissioner to adopt implementing regulations.

The act exempts the commissioner's decision from the administrative procedure law that permits a person aggrieved by the decision to request a hearing. Instead, it permits an aggrieved person to file an appeal with Hartford Superior Court within 30 days of when the decision is mailed to the affected parties. The court may grant equitable relief.

The act removes from the preexisting condition definition that applies to individual health insurance policies, excluding short-term policies, a physical or mental condition that manifested itself during the 12 months before coverage became effective. Thus, it defines a preexisting condition as a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 12 months before

coverage became effective. Under prior law, a short-term health insurance policy issued on a nonrenewable basis for six months or less was exempt from preexisting condition coverage requirements if it disclosed in plan materials that preexisting conditions are not covered. The act imposes preexisting condition exclusion limitations on these short-term policies and requires insurers and HMOs to use specific disclosure language.

EFFECTIVE DATE: October 1, 2007

Background

APPROVAL PROCESS

The act requires an insurer or HMO to apply for the insurance commissioner's approval to rescind, cancel, or limit benefits under a health insurance policy, contract, or certificate based on information the enrollee provided or omitted from the insurance application. The commissioner must prescribe the approval application form.

The insurer or HMO must provide a copy of the completed approval application to the enrollee, or enrollee's representative, who then has seven business days to submit relevant information to the commissioner. Within 15 days of receiving the enrollee's submission, the commissioner must mail a written decision to the enrollee; the enrollee's representative, if any; and the insurer or HMO.

APPLICATION OF REQUIREMENTS

The rescission, cancellation, and limitation requirements apply to health insurers and HMOs issuing policies or contracts that cover:

1. basic hospital expenses,
2. basic medical-surgical expenses,
3. major medical expenses,
4. accident,
5. limited benefits, and
6. hospital or medical services.

SHORT-TERM POLICY PREEXISTING CONDITION EXCLUSION

The act prohibits a short-term health insurance policy issued on a nonrenewable basis for six months or less from excluding coverage of a preexisting condition for more than 12 months from the policy effective date. It defines "preexisting condition" as a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 24 months before coverage became effective.

The act requires the policy, coverage application, and sales brochure for the short-term coverage to conspicuously include the following statement in at least 14-point bold face type:

THIS POLICY EXCLUDES COVERAGE FOR CONDITIONS FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS RECOMMENDED OR RECEIVED DURING THE TWENTY-FOUR MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF COVERAGE.

If an insurer or HMO issues consecutive short-term policies to the same person, it must subtract the time the person was covered by the former policy or policies from any

subsequent policy's preexisting condition exclusion period. The act specifies that it does not require a short-term policy to be issued or renewed.

Preexisting Condition Coverage Requirement

State law prohibits health insurance policies from excluding coverage for preexisting conditions for more than 12 months from the insured's policy effective date. It requires policies (excluding short-term policies) to provide coverage for preexisting conditions to a newly insured individual previously covered for the condition under a former plan if the former plan terminated no more than 120 days before the new policy's effective date. In the case of a new group member, coverage for a preexisting condition is required if (1) the former plan terminated because of an involuntary loss of employment within 150 days before the effective date of the new plan and (2) the member applies for the succeeding policy within 30 days of initial eligibility. If the person was not covered for the preexisting condition under the former policy, the new policy must subtract from the subsequent policy's preexisting condition exclusion period the time the person was covered by the former policy.

RELATED LAW

Insurance Fraud

A person is guilty of insurance fraud when he or she, with the intent to injure, defraud, or deceive any insurance company, knowingly gives, or assists in giving, the insurer any false, incomplete, or misleading written or oral statement as part of, or in support of, any insurance application or claim, that is material to the application or claim.

Public Act 07-178 (House Bill 7263)

An Act Concerning Health Care Centers and Insolvency Protection

(Signed by Governor 7/5/07)

This act makes several changes to laws affecting health care centers (i. e., HMOs). It requires an HMO to deposit \$500,000 with the insurance commissioner or designated trustee. The commissioner must use the deposit to provide health care services to the HMO's enrollees if the HMO is placed in receivership (i. e., rehabilitation or conservation) and may use them for related administrative costs.

By law, an HMO may provide out-of-network (OON) benefits to its enrollees, subject to certain financial requirements. Prior law prohibited an HMO's OON benefits from exceeding 10% of its total quarterly health care expenditures (i. e., claims and expenses). The act instead permits OON benefits to exceed 10% of total expenditures if the HMO first (1) obtains the insurance commissioner's approval and (2) deposits an amount equal to at least 120% of its uncovered expenditures with the commissioner or designated trustee. Prior law required contracts between an HMO and a contracted health care provider to specify that if the HMO failed to pay the provider, the enrollee would not be liable for the amount the HMO owed. The act instead requires the contract to include language it

specifies that holds enrollees harmless (i. e., not liable) for amounts the HMO owes. It also requires the contract to inform the provider that it is an unfair trade practice to (1) ask an enrollee for more than his or her copayment or deductible or (2) report an enrollee to a credit agency for not paying a bill for which the HMO is liable.

EFFECTIVE DATE: October 1, 2007

Background

RECEIVERSHIP DEPOSIT

The act requires each HMO to deposit with the commissioner cash, securities, any combination of these, or other measures acceptable to the commissioner. At the commissioner's discretion, deposits may be given to any acceptable organization or trustee through which a custodian or controlled account is used. The deposit must be worth at least \$500,000 at all times. An HMO in operation on October 1, 2007 must deposit \$250,000 (presumably in 2007) and another \$250,000 in the second year (presumably 2008) to meet the requirement.

The act specifies that an HMO's deposits and all income from them are the HMO's admitted assets when determining its net worth. An HMO that has made a securities deposit may withdraw all or part of it after making a substitute deposit of equal amount and value. The insurance commissioner must approve any securities before they are deposited.

The act requires that the deposits be used to protect the interests of the HMO's enrollees and to assure continuation of health care services to them when the HMO is in rehabilitation or conservation. It permits the commissioner to use the deposits for administrative costs directly related to a receivership or liquidation. If the HMO is placed in rehabilitation or liquidation, the deposit is considered an asset subject to the provisions of the Insurers Rehabilitation and Liquidation Act.

UNCOVERED EXPENDITURES DEPOSIT

The act requires an HMO to place an uncovered expenditures insolvency deposit with the insurance commissioner, or with an acceptable organization or trustee through which a custodial or controlled account is maintained, whenever uncovered expenditures exceed 10% of its total health care expenditures.

The deposit must be in cash or securities acceptable to the commissioner and must at all times have a fair market value equal to 120% of the HMO's uncovered expenditures liability for enrollees in Connecticut, including claims incurred but not yet reported to the HMO. The HMO must calculate the deposit amount as of a month's first day and maintain that amount for the rest of the month. The act requires the HMO to file with the insurance commissioner, within 45 days after each quarter ends, a financial report demonstrating compliance.

Under the act, the uncovered expenditures insolvency deposit is in addition to the \$500,000 receivership deposit. It and all income from it are the HMO's admitted assets when determining net worth, and may be withdrawn quarterly with the commissioner's approval. The act permits an HMO to withdraw all or part of the deposit if (1) a substitute deposit of equal amount and value is made, (2) the fair market value exceeds the amount of the

required deposit, or (3) the required deposit is reduced or eliminated. Deposits, substitutions, or withdrawals require the commissioner's prior written approval. The act requires that the deposit be held in trust separate and apart from all other money, funds, and accounts and it may be used only as provided. It permits the commissioner to use the deposit for paying enrollees' claims for uncovered expenditures and related administrative costs. The commissioner must pay claims on a prorated basis based on available assets. Partial distribution may be made pending final distribution. Any deposit remaining must be paid into the HMO's liquidation or receivership. The act permits the commissioner to adopt regulations that set the time, manner, and form for filing uncovered expenditure claims. The commissioner may also adopt regulations or issue an order requiring an HMO to file annual, quarterly, or more frequent reports deemed necessary to demonstrate compliance. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

PROVIDER CONTRACT HOLD HARMLESS PROVISION

The act requires a contract between an HMO and a participating provider to contain the language it includes or a variation the insurance commissioner approves. The language specifies that the provider and HMO agree that if the HMO does not pay the provider, becomes insolvent, or breaches the contract, the provider will not collect or attempt to collect the amount the HMO owes from the HMO's enrollee or take any recourse against him or her. It also specifies that the provider will continue to render health care services to the enrollee for the period of time for which the enrollee's premiums were paid or until he or she is discharged from an inpatient facility, whichever is longer.

Uncovered Expenditures

"Uncovered expenditures" are health care costs an HMO is obligated to pay, but for which an enrollee may be liable if the HMO is insolvent. Uncovered expenditures do not include (1) expenses for which a provider has agreed not to bill the enrollee even if the HMO does not pay the provider or (2) services another person or organization, other than the HMO, guarantees, insures, or assumes.

Insurers Rehabilitation and Liquidation Act

The Insurers Rehabilitation and Liquidation Act gives the insurance commissioner broad authority to supervise, rehabilitate, or liquidate a financially impaired or insolvent HMO to protect the interests of enrollees, claimants, creditors, and the general public. Among other actions, the commissioner can void fraudulent transfers, preferences, and liens; seek recovery of premiums; dispute claims; prohibit certain financial transactions; and distribute an insolvent HMO's remaining assets to enrollees and other claimants.

Unfair Trade Practice

The Connecticut Unfair Trade Practices Act (CUTPA) prohibits businesses from engaging in unfair and deceptive acts or practices. It allows the Department of Consumer Protection commissioner to define "unfair trade practice" in regulations, investigate complaints, issue cease and desist orders, order restitution in cases involving less than \$5,000, enter into

consent agreements, ask the attorney general to seek injunctive relief, and accept voluntary statements of compliance. It also allows individuals to sue. Courts may issue restraining orders; award actual and punitive damages, costs, and reasonable attorneys fees; and impose civil penalties of up to \$5,000 for willful violations and \$25,000 for violation of a restraining order.

Public Act 07-225 (House Bill 7262)
An Act Concerning Electronic Insurance Filings
(Signed by Governor 7/11/2007)

This act makes various changes in insurance company financial reporting requirements. Prior law required all insurers, HMOs, and fraternal benefit societies doing business in Connecticut to annually file financial statements by March 1 and audited financial reports by June 1 with the insurance commissioner. The act (1) limits the annual reporting requirements to domestic and foreign companies, (2) requires the financial statements to be complete when filed, and (3) requires the companies to electronically file the statements and reports with the National Association of Insurance Commissioners (NAIC). Domestic companies that file on time with NAIC must still submit paper copies to the commissioner, but foreign companies do not. By law, the commissioner may require an insurer, HMO, or fraternal benefit society to file quarterly financial statements. Under the act, if the company electronically files the reports with NAIC on time, then it does not have to give the commissioner paper copies. By law, a company that fails to report as required must pay a \$100 fine for each day a report is late. In addition, a fraternal benefit society, upon notice from the commissioner, loses its authority to operate in Connecticut while in default.

EFFECTIVE DATE: October 1, 2007

Background

Domestic, Foreign, Alien, and Unauthorized Companies

The Insurance Department licenses and regulates domestic, foreign, and alien companies to transact insurance in the state. A domestic company is formed under Connecticut laws. A foreign company is formed under the laws of another state or U. S. territory. An alien company is formed under another country's laws. An unauthorized company is not licensed or admitted to transact insurance business in the state.

Acts of Direct Interest to the Insurance Department

Life and Health

Public Act 07-2 (House Bill 8002)

An Act Implementing the Provisions of the Budget Concerning Human Services and Public Health

(Signed by Governor 6/26/2007)

This act makes numerous changes to human services and public health statutes and establishes the Charter Oak Health Plan. Only those sections of interest to the Connecticut Insurance Department are summarized below. The link to the entire summary is:

<http://www.cga.ct.gov/2007/BA/2007HB-08002-R00SS1-BA.htm>

Sections 18-20 — THIRD PARTY LIABILITY AND MEDICAID COVERAGE

Obligation of Insurers to Provide Information

Federal law requires states, as a condition of receiving federal Medicaid matching funds, to enact laws requiring insurers to provide certain information to DSS. Medicaid is generally the payer of last resort. Thus, DSS must exhaust other payment sources (e. g. , private insurance) before paying for health care services provided to Medicaid recipients. By law, individuals are expected to fully disclose when they have other coverage. The bill requires health insurers to provide certain information to the DSS commissioner, when requested, regardless of whether they bear any financial risk for a Medicaid recipient's claims. As used in the bill, "health insurer" includes a self-insured plan; group health plan, as defined in federal law; service benefit plan; managed care organization; health care center; pharmacy benefit manager (PBM); dental benefit manager, or other party that is by statute, contract, or agreement legally responsible for paying health care claims.

The bill requires health insurers to provide the information in a manner and format the commissioner or his designee prescribes, that identifies, determines, or establishes third-party coverage. This includes information necessary to determine during what period a person, or his or her spouse or dependents, is or was covered by a health insurer and the nature of the coverage provided, including the insurance plan's name, address, and identifying number. The insurer must also provide this information to all third-party administrators, PBMs, dental benefit managers, or other entities with which it arranges to adjudicate health care claims.

Under current law, state-licensed insurance companies must conduct automated data matches to identify this coverage if (1) the DSS commissioner requests it and (2) compatible data elements are available, and the law requires the commissioner to reimburse the companies for the costs of conducting the matches. The bill instead requires

health insurers, as more broadly defined by the bill, to do these matches at the commissioner's request or allow the commissioner or his designee to conduct them.

Insurers' Obligation to Assist DSS as Condition of Operating in State

With respect to individuals eligible for or receiving Medicaid, the bill requires health insurers, as a condition of operating in Connecticut, to:

1. provide to the DSS commissioner or his designee, all third-party administrators, PBMs, dental benefits managers, and other entities with which the insurer arranges to adjudicate health care claims any information the commissioner or his designee prescribes that is necessary for determining whether there is available coverage and the coverage plan's name, address, and identifying number;
2. accept the state's right of recovery and a person's assignment of benefits to the state for payment of a health care service provided for which Medicaid paid;
3. respond to any inquiry from the commissioner or his designee regarding a health care claim submitted within three years from the date the service was provided; and
4. agree not to deny a claim that the state submits solely based on its submission date, claim form, type or format, or failure to present proper documentation at the "point-of-sale" that is the basis of the claim if (A) the state or its agent submits the claim within the three-year period and (B) the state begins any legal action to enforce its rights with respect to the claim within six years of the claim submission.

Under current law, no individual or group accident, health, accident or health, medical expense, medical service plan, self-insured plan, or self-funded plan subject to ERISA can contain provisions that have the effect of denying or limiting benefits or excluding coverage because the services are provided to someone who is eligible for or receiving Medicaid. The bill instead applies the prohibition to the bill's broadened list of health insurers' plans and extends it to include provisions that limit enrollment in private health care coverage.

DSS Subrogated to Any Right of Recovery for Medicaid Services Rendered

By law, DSS is subrogated (i. e., entitled) to any right of recovery or indemnification that a Medicaid applicant or recipient, or his or her legally liable relative, has against an insurer for the costs of hospitalization, pharmacy, physician, and nursing services provided, up to the amount DSS spent on such services. The bill extends this provision to the broadened list of health insurers and any other legally liable third party. And it adds behavioral health and long-term care services to the list of Medicaid-covered services for which DSS can recover.

Applying for or receiving Medicaid is deemed by law to be a subrogation assignment and an assignment of claims for benefits to DSS. Insurers must pay DSS directly under such an assignment. DSS can further assign its right to payment to a health care provider participating in Medicaid. Currently, providers must notify the "private" insurer of the assignment when rendering health care services. If the provider fails to do this, he or she is ineligible for DSS reimbursement. The bill requires notification to a health insurer, as it more broadly defines the term or other legally liable third party.

Requirement to Pay Claims

The bill specifies that claims for recovery or indemnification that DSS or its designee submit to health insurers may not be denied solely based on the submission date, claim

form, type or format, or failure to present proper documentation at the “point-of-sale” that is the basis of the claim if (A) the state or its agent submits the claim within three years from the date of service and (B) any legal action to enforce its rights with respect to the claim the state begins within six years of the claim submission.

EFFECTIVE DATE: July 1, 2007

Section 21 — PHARMACY CLAIMS FOR BENEFICIARIES WHO HAVE OTHER INSURANCE AND FRAUD UNDER DSS PROGRAMS AND MEDICARE PART D SUPPLEMENTAL NEEDS FUND

The bill prohibits any pharmacy from claiming payment from DSS under a DSS-administered medical assistance program or the Medicare Part D Supplemental Needs Fund for drugs prescribed to people who have other prescription drug insurance coverage unless the coverage has been exhausted and the person is otherwise eligible for the program or assistance from the Fund. It requires DSS to recoup from the submitting pharmacy any claims it submitted to DSS which DSS paid when other insurance coverage is available.

Under the bill, DSS must investigate a pharmacy that consistently submits ineligible payment claims to determine whether the pharmacy is in violation of its medical assistance provider agreement or is committing fraud or abuse in the program. Based on DSS's findings in the investigation, the bill allows it to take action against the pharmacy in accordance with state and federal law.

EFFECTIVE DATE: Upon passage

Section 23 — CHARTER OAK HEALTH PLAN

The bill establishes a Charter Oak Health Plan for residents who have been uninsured for at least six months and are ineligible for publicly funded health care.

Contracts for Health Care

In establishing the plan, the bill authorizes the Department of Social Services (DSS) commissioner to enter into contracts to provide comprehensive health care for the state's uninsured residents. It requires the commissioner to conduct outreach to facilitate enrollment in the plan.

Cost Sharing

The bill requires the DSS commissioner to impose cost sharing for plan participants. This may include:

1. monthly premiums;
2. a maximum \$ 1,000 annual deductible;
3. coinsurance of no more than 20%, once the deductible is met;
4. tiered co-payments for prescription drugs, depending on whether the drug is on a formulary, is a brand name, or whether it is mail-ordered;
5. no fees for emergency visits to hospital emergency rooms and a maximum \$ 150 fee for nonemergency visits; and
6. a \$ 1 million lifetime benefit limit.

Premium Assistance

Residents purchasing the insurance pay premiums directly to the insurer and qualify for premium assistance if their income is less than 300% of the FPL. The assistance amounts are shown below.

<i>Income Level</i>	<i>Monthly Premium Assistance</i>
Below 150% of FPL	\$ 175
150% to 185% of FPL	\$ 150
185% to 235% of FPL	\$ 75
235% to 300% of FPL	\$ 50

Coverage

The bill requires the DSS commissioner to determine minimum requirements for the plan's amount, duration, and scope of benefits, which cannot include a pre-existing condition exclusion. Each participating insurer must provide an internal grievance process through which an insured person can request and receive a review of any coverage denial.

Allowable Plans

The bill authorizes DSS to contract with any of the following entities to provide coverage:

1. managed care organizations,
2. a consortium of federally qualified health centers and other state-funded, community-based health care providers; and
3. other health care provider consortia established to serve plan participants.

The bill specifies that the above consortia are not subject to the laws governing MCOs, hospital service corporations, and medical service corporations. These laws include annual financial filings with the Department of Insurance (DOI), DOI rate approval, and investment limitations. Before these providers may participate in the plan, the DSS commissioner must certify them according to criteria he or she establishes, which must include minimum reserve fund requirements.

The bill requires the commissioner to seek proposals from the entities based on the cost-sharing and benefits (presumably those that the entities offer). It allows the commissioner to approve an alternative plan to make coverage options available to eligible residents.

Regulations; Exception to Six-Month Crowd Out and Enrollment Restrictions

The bill permits the DSS commissioner to implement policies and procedures for administering the plan while in the process of adopting them as regulations, if notice of intent to adopt the regulations is published in the Connecticut Law Journal within 20 days of implementation. The policies and procedures are valid until the regulations are adopted. The bill allows the policies and regulations to include an exception to the six-month period of noninsurance and requirements for open enrollment periods, and limiting enrollees' ability to change plans between these periods.

EFFECTIVE DATE: July 1, 2007

Section 24 — SCHOOL DISTRICT REPORTING OF STUDENT INSURANCE RATES

The bill requires local or regional school boards to require all students in their jurisdiction to report whether they have health insurance. The DSS commissioner, or his designee, must provide information to the boards on state-sponsored health insurance programs for children, including application assistance. The boards must provide this information, and application assistance, to the student's parent or guardian. (HB 8005 limits the districts'

obligation to offer the information to only those parents and guardians whose children are identified as uninsured.)

EFFECTIVE DATE: July 1, 2007

Sections 51 - 52 – INSURANCE COVERAGE FOR LEAD SCREENING The bill requires individual and group health insurance policies to cover the bill's lead screening and risk assessments mandates. The requirement applies to Connecticut policies delivered, issued for delivery, amended, renewed, or continued on or after January 1, 2009.

EFFECTIVE DATE: January 1, 2009

Sections 64, 65 & 69 — DEPENDENT CHILDREN COVERAGE EXTENSION

The bill amends provisions in PA 07-185 that raise, from age 22 to 25, the age to which group comprehensive and individual health insurance policies that cover children must do so. That act limited the coverage extension to children who reside in Connecticut; the bill extends coverage to full-time students at accredited out-of-state colleges and universities and children who live out-of-state with a custodial parent pursuant to a court order.

It makes both the group and individual policy coverage provisions effective January 1, 2009. Under PA 07-185, the group provision was effective July 1, 2007, and the individual policy provision was effective October 1, 2007.

EFFECTIVE DATE: January 1, 2009

Section 67 — HEALTHFIRST CONNECTICUT AUTHORITY

The bill amends PA 07-185 to add the insurance commissioner and health care advocate or their designees as nonvoting members of this authority, which was created to recommend alternatives for affordable quality health care coverage for un- and underinsured people and cost containment measures and insurance financing mechanisms.

EFFECTIVE DATE: Upon passage

Public Act 07-18 (Senate Bill 229)

An Act Concerning Lists of Providers and Notification of Termination or Withdrawal of Primary Care Physicians

(Signed by Governor 5/7/2007)

By law, managed care organizations (MCOs) must annually provide people enrolled in a health plan a list of health care providers participating in the plan. This act specifies that the list must be provided in writing or through the Internet at the enrollee's option. Prior law required an MCO to notify an enrollee as soon as possible when his or her primary care physician left the MCO's provider network. The act limits this requirement to managed care plans that require an enrollee to select a primary care physician.

EFFECTIVE DATE: October 1, 2007

Public Act 07-28 (Senate Bill 1103)

An Act Concerning Nonforfeiture Benefit Requirements with Respect to Long-Term Care Policies

(Signed by Governor 5/18/2007)

This act prohibits an insurer from issuing or delivering a long-term care policy on or after July 1, 2008 unless it had offered the prospective insured an optional nonforfeiture benefit during the policy solicitation or application process. The offer may form a rider to the policy. If the nonforfeiture option is declined, the insurer must give the insured a contingent benefit if the policy lapses (i. e., terminates because the insured stops paying the premium). The contingent benefit must be available to the insured for a period of time after any substantial premium increase.

The act requires the insurance commissioner to adopt regulations by July 1, 2008 to implement the nonforfeiture option and contingent benefit requirements. The regulations must specify (1) the nonforfeiture benefit standards and type, (2) the time period a contingent benefit must be available, and (3) what constitutes a substantial premium increase. They must also be in accord with the National Association of Insurance Commissioners' long-term care insurance model regulation. The act's requirements apply to insurance companies, fraternal benefit societies, hospital or medical service corporations, and HMOs.

EFFECTIVE DATE: July 1, 2007

Background

Nonforfeiture and Contingent Benefits

A nonforfeiture benefit is an insurance policy provision specifying that an insured's equity in the policy cannot be forfeited. It offers the insured options for receiving the cash value of a policy that lapses. Some common types of nonforfeiture benefits are the policy's cash surrender value, other insurance, or a loan. If the insured does not elect a nonforfeiture option, a policy specifies one that is automatically effective (i. e., a contingent benefit upon lapse).

Long-Term Care Policy

Connecticut law defines a long-term care policy as an individual health insurance policy that provides expense-incurred, indemnity, or pre-paid benefits for the necessary care or treatment of an injury, illness, or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute hospital, including a nursing home and an insured's own home. Benefits are effective for at least one year following an elimination period (i. e., a time period after the onset of the injury, illness, or function loss during which no benefits are payable). It excludes policies that provide Medicare supplement, basic medical-surgical expense, hospital confinement indemnity, major medical expense, disability income protection, accident only, specified accident, and limited benefit health coverage.

Related Act

PA 07-226 requires a long-term care policy elimination period of (1) no more than 100 days of confinement or (2) between 100 days and two years of confinement if an irrevocable trust is in place that is estimated to be sufficient to cover the person's confinement costs during that period.

Public Act 07-48 (House Bill 5259)

An Act Concerning Refunds of Prepaid Premiums Made by Senior Citizens to Health Insurance Providers for Medicare Supplement Policies

(Signed by the Governor 5/22/2007)

This act requires insurers to refund to a person who cancels his or her Medicare supplement policy before the policy's coverage period ends any prepaid premium. The requirement applies to insurance companies, fraternal benefit societies, hospital or medical service corporations, HMOs, and other entities that deliver, issue, continue, or renew a Medicare supplement policy or certificate in Connecticut.

A Medicare supplement policy (also referred to as “Medigap”) is a health insurance policy that covers some of the health care costs that Medicare does not cover. It must meet minimum standards set in federal law.

EFFECTIVE DATE: October 1, 2007

Public Act 07-67 (Senate Bill 389)

An Act Concerning Hospitalization at an Out-of-Network Facility During Treatment in Cancer Clinical Trials

(Signed by Governor 5/30/2007)

By law, individual and group health insurance policies and HMO contracts must cover medically necessary hospitalization services and other routine patient care costs associated with certain cancer clinical trials. This act specifies that the required hospitalization coverage includes treatment at an out-of-network facility if (1) it is unavailable at an in-network facility and (2) the clinical trial sponsors are not paying for it. (An out-of-network facility is one that has not contracted with the insurer or HMO to provide health care services to enrollees. An in-network facility has contracted.)

Prior law subjected the required coverage to the policy's or contract's terms and limitations, including out-of-network limitations. The act instead requires the out-of-network hospital and insurer or HMO to make the out-of-network hospital treatment available at no greater cost to the patient than if treatment was available at an in-network facility. Thus, the patient is only responsible to pay any copayment, coinsurance, or deductible required under the policy or contract for in-network services.

EFFECTIVE DATE: Upon passage

Background

Coverage for Cancer Clinical Trials

By law, health insurers and HMOs must cover routine patient care costs associated with certain cancer clinical trials. A “cancer clinical trial” is an organized, systematic, scientific study of interventions for cancer (1) treatment or palliation or (2) prevention. If the trial is for cancer prevention, it must be a Phase III trial conducted at multiple institutions. (Phase III clinical trials compare a new drug or surgical procedure to the current standard of treatment.) The law applies to trials conducted under an independent, peer-reviewed protocol approved by (1) one of the National Institutes of Health, (2) a National Cancer Institute-affiliated cooperative group, (3) the Food and Drug Administration as part of an investigational new drug or device exemption, or (4) the U. S. Departments of Defense or Veterans' Affairs.

Payment to Out-of-Network Providers

By law, an insurer or HMO must pay out-of-network providers (including hospitals) the lesser of (1) the lowest contracted daily fee schedule or case rate it pays its Connecticut in-network providers for similar services or (2) billed charges. Out-of-network providers are prohibited from collecting more than the total of the amount paid by the insurer or HMO and the insured's deductible and copayment.

Public Act 07-75 (House Bill 7055) **An Act Concerning Medical Necessity and External Appeals** *(Signed by Governor 5/30/2007)*

This act requires insurers, HMOs, and other entities to include a particular definition of “medically necessary” or “medical necessity” in individual and group health insurance policies and contracts. For insurers and HMOs that have entered into a federal court-approved class action settlement with physicians, the requirement does not apply until the settlement's expiration date.

The act extends the timeframe for appealing to the insurance commissioner (i. e., filing an external appeal) after a person has exhausted a company's internal grievance procedures. Under prior law, after receiving a final written claim denial based on a lack of medical necessity or determination not to certify an admission, service, procedure, or extension of hospital stay, a person had 30 days to file an external appeal. The act extends this to 60 days. It also makes a conforming change.

EFFECTIVE DATE: January 1, 2008, except for the appeal provision, which is effective upon passage.

REQUIRED DEFINITION

The act prohibits insurers and HMOs from delivering or issuing for delivery any individual or group health insurance policy in Connecticut unless it contains the following definition: “Medically necessary” or “medical necessity” means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms,

and that are (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site, and duration and considered effective for the patient's illness, injury, or disease; and (3) not primarily for the convenience of the patient, physician, or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

APPLICATION

Medically Necessary Provisions

The act's medical necessity provisions apply to insurers, HMOs, hospital and medical service corporations, and other entities delivering, issuing, renewing, continuing, or amending individual or group health insurance policies in Connecticut beginning January 1, 2008 that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, (4) accidents only, (5) limited benefits, or (6) hospital or medical services.

Appeal Provision

The act's appeal provision applies to any entity delivering, issuing, renewing, or amending individual or group health insurance policies in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; (4) limited benefits; (5) specified diseases; or (6) hospital or medical services, including those issued by HMOs.

Background

Class Action Settlements

Aetna, CIGNA, Health Net, Prudential, Anthem/WellPoint, and Humana entered into settlement agreements that apply nationally with over 900,000 physicians and state and county medical societies in the class action lawsuits consolidated as *In re Managed Care Litigation* in the U. S. District Court for the Southern District of Florida. The settlements were approved at various times between 2003 and 2006. Other defendants, including PacifiCare, United, and Coventry, did not enter into settlement agreements with the physicians. The lawsuits alleged that since 1990, these companies engaged in a conspiracy to improperly deny, delay, or reduce payment to physicians by engaging in several types of allegedly improper conduct, including failing to pay for medically necessary services in accordance with member plan documents. Under the settlement terms, each company has agreed to use a specified "medical necessity" definition. The settlements have expiration dates that vary by company. When they expire, the companies will no longer be bound to follow the definition contained in the settlements, at which time they are required to use the act's definition.

Public Act 07-96 (House Bill 5496)
An Act Regulating Limited Benefit Medical Plans
(Signed by Governor 6/11/2007)

Beginning January 1, 2008, this act requires each individual and group health insurance policy, contract, or certificate issued in Connecticut that provides limited coverage, and any related advertising, marketing, and enrollment material, to include a conspicuous statement disclosing that the plan does not provide comprehensive medical coverage. It also prohibits, as of that date, an insurer, HMO, or other entity from replacing an employer-sponsored comprehensive health insurance plan with a policy that provides limited coverage.

EFFECTIVE DATE: July 1, 2007

Background

Definition

The act defines "limited coverage" as a health insurance policy that includes an annual maximum benefit of less than \$100,000 or a per-service or -condition benefit limit of less than \$20,000. The policy covers basic hospital expenses, basic medical-surgical expenses, major medical expenses, or hospital or medical services, including an HMO contract.

Conspicuous Statement

Beginning January 1, 2008, each individual and group health insurance policy, contract, and certificate providing limited coverage and any related advertising, marketing, and enrollment material must include a conspicuous statement printed in capital letters and at least 12-point bold face type that says:

This limited health benefits plan does not provide comprehensive medical coverage. It is a basic or limited benefits policy and is not intended to cover all medical expenses. This plan is not designed to cover the costs of serious or chronic illness. It contains specific dollar limits that will be paid for medical services which may not be exceeded. If the cost of services exceeds those limits, the beneficiary and not the insurer is responsible for payment of the excess amounts. The specific dollar limits are as follows: (The insurer is to specify the limits.)

Public Act 07-155 (House Bill 6893)
An Act Concerning Expanded Outreach and Communication Activities by the Choices Health Insurance Assistance Program
(Signed by Governor 6/25/2007)

This act expands the statutory role of the Department of Social Services' CHOICES health insurance assistance program in disseminating information (including preparing and distributing written material) and providing advice to Medicare beneficiaries. Under the act, the program must provide information on the federal Medicare Part D prescription drug program and long-term care options in the state. The act includes the Medicare Part D

program in the list of mandatory Medicare-related information in the Connecticut Medicare consumer guide. CHOICES develops and distributes this guide after consulting with the insurance commissioner and other organizations.

The act also requires CHOICES to collaborate with other state agencies and entities in developing consumer-oriented websites that provide information on Medicare plans, including Medicare Part D plans and available long-term care options. It adds CHOICES personnel designated by the social services commissioner to the group charged with developing the state's long-term care website, which began operating in 2006. (The other entities are the Office of Policy and Management, Select Committee on Aging, Commission on Aging, and Long-term Care Advisory Council.)

EFFECTIVE DATE: July 1, 2007

Public Act 07-185 (Senate Bill 1484)

An Act Concerning the Healthfirst Connecticut and Healthy Kids Initiatives

(Signed by Governor 7/10/2007)

This act expands access to public health insurance by making a number of changes in the HUSKY program and insurance statutes. Only those sections of interest to the Connecticut Insurance Department are summarized below. The link to the entire summary is:

<http://www.cga.ct.gov/2007/SUM/2007SUM00185-R01SB-01484-SUM.htm>

Sections 15-17 — DEPENDENT CHILDREN COVERAGE EXTENSION

The act raises, from age 23 to 26, the age to which group comprehensive and individual health insurance policies that cover children must do so. Prior law required coverage for unmarried, dependent children until they turn 19, or 23 for full-time students at an accredited school. The act eliminates the requirements that children be dependent or full-time students and limits the continuing coverage to those who live in Connecticut. (PA 07-2, JSS, extends coverage for children who attend accredited out-of-state colleges or who live in another state with a custodial parent.)

The act applies to:

1. individual health insurance policies delivered, issued, amended, or renewed on or after October 1, 2007 that cover (a) basic hospital and medical surgical expenses, (b) major medical expenses, (c) accidents, (d) limited benefits, and (e) hospital or medical services, including HMO contracts; and
2. group comprehensive health care plans (a minimum plan all health insurers must offer) beginning July 1, 2007.

EFFECTIVE DATE: July 1, 2007 (PA 07-2, JSS, makes these changes effective January 1, 2009)

Sections 18-21 — HEALTH REINSURANCE ASSOCIATION (HRA) PLANS

By removing a provision that prohibits the sale of special health care plans to small employers after January 1, 1995, the act permits such plans to be sold again. Small employers are those with 50 or fewer uninsured employees and self-employed people. By law, each small-employer insurer must offer small employers a special health care plan. A small employer with 10 or fewer employees, most of whom are low-income, does not have to offer a plan. Instead, the insurer must refer the employer to the HRA. The act potentially makes these plans available to more employers by raising the income eligibility limit for a low-income individual or employee from 200% to 300% of FPL. HRA must develop premium rates and administer the plans without profit or loss.

EFFECTIVE DATE: July 1, 2007

Section 22 — CONSUMER HEALTHCARE WEBSITE

The act requires the Healthcare Advocate's Office, by October 1, 2008 and within available appropriations, to create and maintain an Internet website for consumer health care information. At a minimum, the website must contain (1) information about wellness programs, such as disease prevention and health promotion, available in various regions; (2) hospital quality and experience data; and (3) a link to the Insurance Department's managed care consumer report card.

EFFECTIVE DATE: October 1, 2007

Section 23 — PRE-TAX HEALTH INSURANCE PREMIUM DEDUCTIONS

The act requires every employer that deducts health insurance premiums from its employees' pay to allow employees to make these payments with pre-tax earnings to the extent permitted under IRS Code section 125. That section allows employers to offer employees a choice between cash salary and a variety of nontaxable, qualified benefits such as health, disability, and group life insurance. Employee contributions are made before federal and most state income taxes and Social Security taxes are calculated.

EFFECTIVE DATE: October 1, 2007

Sections 30 & 39 — HEALTHFIRST CONNECTICUT AUTHORITY

The act creates a 13-member HealthFirst Connecticut Authority to:

1. evaluate alternatives for providing quality, affordable, and sustainable health care for all state residents, including a single-payer system and employer-sponsored insurance;
2. recommend (a) ways to contain health care costs and improve health care quality, including health information technology; (b) disease management and other methods to improve care for people with chronic diseases; (c) monitoring and reporting on cost, quality, and care utilization; and (d) ways to encourage or require providing health care coverage to certain groups through participation in an insurance pool; and
3. recommend ways to finance insurance for state residents, including ways to maximize federal funding for subsidies; contributions from employers, employees, and individuals; and ways to pay the state's share of costs.

The panel must report its recommendations, including recommended strategies for increasing health care access, by December 1, 2008, to the Public Health, Human Services, and Insurance committees.

Legislative leaders and the governor appoint 10 members, some of whom must represent specific interests, as Table 1 shows. The DPH and DSS commissioners and the comptroller, or their designees, are ex-officio, nonvoting members. **(PA 07-2, JSS, adds the insurance commissioner and health care advocate as ex-officio, nonvoting members.)** All members must be familiar with the Institute of Medicine's health care reform principles and be committed to making recommendations consistent with them.

Table 1: HealthFirst Connecticut Appointments

Appointing Authority (Number of Appointments)	Appointees
Governor (2)	Health quality or patient safety advocate Person with information technology experience
Senate president pro tempore (2)	Representative of businesses with fewer than 50 employees Person with community-based health experience
House speaker (2)	Health care provider Representative of businesses with 50 or more employees
Senate majority leader (1)	Labor representative
House majority leader (1)	Consumer representative
Senate minority leader (1)	Hospital representative
House minority leader (1)	Insurance company representative

All appointments must be made within 30 days after the act is enacted, and if a vacancy occurs, the appointing authority must fill it within 30 days. The speaker and president pro tempore each choose one chairperson, and the two must schedule the panel's first meeting no more than 60 day's after the act's enactment. If an appointing authority fails to make an initial or vacancy appointment within the 30-day period, the authority chairpeople must do so.

The authority can apply for grants or financial assistance from state and federal agencies, individuals, groups, and corporations. The act appropriates \$500,000 to DPH in FY 09 for the authority (PA 07-2, JSS, removes the appropriation).

EFFECTIVE DATE: Upon passage, except for the appropriation, which is effective July 1, 2008.

Public Act 07-191 (Senate Bill 1213)

An Act Concerning the Financial Security Requirement for Preferred Provider Networks

(Signed by Governor 7/10/2007)

The act revises the formula that determines the amount of financial security preferred provider networks (PPNs) and managed care organizations (MCOs) that contract with PPNs must post, maintain, or arrange for by letter of credit, bond, surety, reinsurance, reserve, or other means. In case of insolvency or nonpayment, the PPN, or another entity the insurance commissioner designates, must use the security to pay the network's health care providers.

Under prior law, the security amount required was the greater of (1) an amount calculated based on the two quarters in the past year in which the largest amounts were owed to network providers, (2) the actual outstanding debt owed them, or (3) another amount the commissioner determined. The act changes the formula's first prong to an amount sufficient for the PPN to pay the providers for two months based on the two months in the past year in which the PPN owed the largest amount to them. It leaves the two other prongs unchanged. By law, the financial security amount maintained may be credited against the network's minimum net worth requirement. The commissioner must review the amount and the calculation on a quarterly basis.

EFFECTIVE DATE: July 1, 2007

Background

PPN Definition

By law, a PPN is an entity that pays health care claims and accepts the financial risk for the delivery of health care services. It establishes, operates, or maintains an arrangement or contract with health care providers relating to (1) health care services the providers render and (2) compensation for such services. It excludes MCOs; workers' compensation preferred provider organizations; individual practice associations or physician hospital associations whose primary function is to contract with insurers and provide services to providers; and licensed clinical laboratories whose primary payments are made to other licensed laboratories or for associated pathology services.

Related Act

PA 07-200 excludes from the PPN definition a pharmacy benefits manager that processes pharmacy claims primarily to administer a health benefit plan's pharmacy benefit.

Public Act 07-197 (Senate Bill 66)

An Act Expanding Insurance Coverage for Specialized Formulas for Children

(Signed by Governor 7/5/2007)

This act requires health insurance policies to cover medically necessary specialized formulas administered under a physician's direction for children up to age 12, instead of age eight. The act applies to group and individual insurance policies delivered, issued for delivery, or renewed in Connecticut after September 30, 2007 that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; (4) accidents only; and (5) hospital or medical services, including HMO contracts. It does not apply to

self-insured benefit plans, which are regulated under the federal Employee Retirement Income Security Act (ERISA).

EFFECTIVE DATE: October 1, 2007

Background

Specialized Formulas

“Specialized formula” is a nutritional formula that is exempt from the federal Food and Drug Administration's general nutritional labeling requirements and is intended for use solely under medical supervision in the dietary management of specific diseases.

Related Act

PA 07-75 requires insurers and HMOs to include a specified “medically necessary” definition in health insurance policies.

Public Act 07-200 (Senate Bill 74)

An Act Requiring the Registration of Pharmacy Benefit Managers

(Signed by Governor 7/6/2007)

This act requires pharmacy benefit managers (PBMs), with exceptions, to obtain a certificate of registration from the Insurance Department before operating in Connecticut. It requires PBMs already operating in the state on January 1, 2008 to obtain one by April 1, 2008 to continue operating here.

PBMs must apply for registration by giving the department (1) a completed application form that contains information on the people running the PBM; (2) a nonrefundable \$50 fee; and (3) evidence of a surety bond that is between \$25,000 and \$1 million. The PBM may request a hearing if the department denies registration. The act permits the insurance commissioner to suspend, revoke, or deny registration for specified causes after notice and hearing. PBMs must apply annually for registration renewal. The act also excludes a PBM that processes pharmacy claims primarily to administer a health benefit plan's pharmacy benefit from the “preferred provider network” (PPN) definition; thus, the PBM does not have to obtain a PPN license or comply with state PPN requirements.

EFFECTIVE DATE: January 1, 2008

Background

PHARMACY BENEFIT MANAGER

Under the act, a PBM is a person that administers the prescription drug, prescription device, or pharmacist services portion of a health benefit plan on behalf of plan sponsors (e. g. , self-insured employers, insurers, labor unions, or HMOs).

REGISTRATION

Application

The act requires a PBM, unless it meets a specified exception (see below), to apply for a certificate of registration from the Insurance Department on a form the department

develops. The application must include the name, address, official position, and professional qualifications of each person responsible for running the PBM. Such people include (1) the principal officers, partners, or association members; (2) all members of the boards of directors, trustees, and executive and governing committees; and (3) any other person exercising control or influence over the PBM. The application must also include the name and address of the PBM's agent for service of process in Connecticut.

Fee and Bond

The PBM must pay a \$50 nonrefundable application fee. It must also provide evidence of a surety bond equal to 10% of one month of claims in Connecticut over a 12-month average, except the bond must be at least \$25,000 and no more than \$1 million.

Issuance, Renewal, Suspension, Revocation, or Denial

Once the insurance commissioner receives a PBM's completed application, fee, and bond evidence, he must either issue the PBM a certificate of registration or deny registration.

Expiration and Renewal. Registration expires annually on December 31. The PBM may apply for renewal by completing a renewal form that the commissioner prescribes and paying a \$50 nonrefundable renewal fee, plus a \$50 penalty fee if paid late. (The act does not specify when a renewal is due or when payment is considered late).

Suspension, Revocation, and Denial. The commissioner may suspend, revoke, or deny a registration for (1) conduct likely to mislead, deceive, or defraud the public or commissioner; (2) unfair or deceptive business practices; or (3) not paying the renewal fee. The act specifies that the commissioner may suspend or revoke a registration only after providing notice and hearing in accordance with the Uniform Administrative Procedure Act (UAPA). Upon denying a registration, the commissioner must notify the PBM of the (1) decision and (2) PBM's right to request a hearing within 10 days of receiving notice. If the PBM requests a hearing, the commissioner must (1) give notice of the grounds for denying the registration and (2) hold a UAPA hearing. If after the hearing the denial is upheld, the PBM may reapply for registration, but it must wait at least one year from the hearing decision to do so.

Investigations

The act permits the commissioner to investigate and hold hearings on any matter covered by the registration requirements; issue subpoenas; administer oaths; compel testimony; and order the production of books, records, and documents. If anyone refuses to comply with the commissioner's orders, the commissioner may apply to Superior Court for a judge to order compliance.

Appeal to Court

The act permits anyone aggrieved by the commissioner's orders or decisions to appeal to Superior Court in accordance with the UAPA.

Regulations

The act requires the commissioner to adopt regulations to implement the registration requirements. The regulations must include the application form and any other required forms and reports.

EXCEPTIONS The act exempts from the registration requirement a PBM that is a line of business or affiliate of a Connecticut-licensed health insurer, HMO, hospital or medical service corporation, or fraternal benefit society. It requires the insurer or other entity to annually notify the insurance commissioner in writing on a department form that it is affiliated with or operating a PBM.

Preferred Provider Network

A PPN enters into contracts with health care providers who agree to deliver health care services to people covered under certain health care plans in exchange for payment. The PPN pays health care claims, taking on the financial risk for the delivery of services. The law excludes from the PPN definition (1) managed care organizations, (2) workers compensation preferred provider organizations, (3) independent practice associations and physician hospital associations that primarily contract with insurers and provide services to providers, and (4) licensed clinical laboratories whose primary payments for contracted or referred services are to other licensed laboratories or for associated pathology services.

Public Act 07-226 (House Bill 7283)
An Act Establishing a Long-Term Care Initiative
(Signed by Governor 7/10/2007)

This act changes the elimination period under a long-term care (LTC) insurance policy. Prior law required an LTC policy to contain a “reasonable” elimination period (i.e., a waiting period after the onset of the injury, illness, or function loss during which no benefits are payable). The act instead requires an elimination period that is (1) up to 100 days of confinement or (2) between 100 days and two years of confinement if an irrevocable trust is in place that is estimated to be sufficient to cover the person's confinement costs during this period.

The act requires that the trust (1) pay the health care provider directly and (2) create an unconditional duty to pay only confinement costs during the elimination period. It specifies that the (1) state, grantor, or person acting on the grantor's behalf may enforce this duty and (2) trust remains subject to taxes and any trustee charges allowed by law. For LTC policies that offer the elimination period trust option, the act requires an insurer to include, (1) in rate filings it submits to the insurance commissioner, how it estimated trust values and (2) on the policy application and face page, a clear and conspicuous statement that the trust may be insufficient to cover all costs incurred during the elimination period.

EFFECTIVE DATE: October 1, 2007

Long-Term Care Policy

An LTC policy is an individual health insurance policy that provides expense-incurred, indemnity, or pre-paid benefits for the necessary care or treatment of an injury, illness, or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, including a nursing home and an insured's own

home, for at least one year after an elimination period. It excludes policies that primarily provide Medicare supplement, basic medical-surgical expense, hospital confinement indemnity, major medical expense, disability income protection, accident only, specified accident, and limited benefit health coverage.

Public Act 07-252 (House Bill 7163)
An Act Concerning Revisions to Statutes Relating to the Departments of Public Health and Social Services and Town Clerks
(Signed by Governor 7/12/2007)

Only those sections of direct interest to the Connecticut Insurance Department are summarized below.

Sections 12 & 13 — ASSISTED LIVING SERVICES AGENCY

The act adds assisted living services agencies to the statutory list of health care institutions and makes a technical change to the definition of such agencies.

EFFECTIVE DATE: October 1, 2007

Sections 23 & 24 — ALCOHOL AND DRUG COUNSELORS

Existing law provides that the alcohol and drug abuse counselor licensure and certification statutes do not apply to the activities of various licensed professionals acting within the scope of their profession, doing work consistent with their training, and not holding themselves out as alcohol and drug counselors. The act amends this exception by (1) removing chiropractors, acupuncturists, physical therapists, and occupational therapists from the exempt list; (2) adding professional counselors; and (3) specifying that “nurses” mean advanced practice registered nurses and registered nurses. It also specifies that the person must be working consistent with his or her license, rather than with his or her “training.”

EFFECTIVE DATE: Upon passage

Sections 70 & 71 — MOBILE FIELD HOSPITAL

All individual and group health policies delivered, issued for delivery, renewed, amended or continued in the state on or after July 12, 2007, shall provide benefits for isolation care and emergency services provided by the state's mobile field hospital. Such benefits shall be subject to any policy provisions that apply to other services covered by such policy.

Mobile field hospital means a modular, transportable facility used intermittently, deployed at the discretion of the Governor, or the Governor's designee, for the provision of medical services at a mass gathering; for the purpose of training or in the event of a public health or other emergency for isolation care purposes or triage and treatment during a mass casualty event; or for providing surge capacity for a hospital during a mass casualty event or infrastructure failure.

EFFECTIVE DATE: Upon Passage

Property and Casualty Division

Public Act 07-5 (Senate Bill 109)

An Act Requiring Automobile Insurance Discounts for Drivers Sixty Years of Age and Over who Complete an Accident Prevention Course

(Signed by Governor 4/26/2007)

This act decreases, from 62 to 60, the age at which a driver is eligible for an automobile insurance policy premium discount for successfully completing a Department of Motor Vehicles-approved accident prevention course.

By law, the premium discount must be at least 5% and apply for at least 24 months. The driver must complete the course within one year before applying for an initial discount. For any future discount, the driver must complete a course within one year before the current discount expires. The premium discount is effective at the policy's next renewal.

EFFECTIVE DATE: October 1, 2007

Public Act 07-25 (Senate Bill 249)

An Act Concerning Medical Malpractice Data Regarding Medical Professionals

(Signed by Governor 5/18/2007)

This act extends to insurers of any “medical professional,” instead of just insurers of physicians, advanced practice registered nurses, or physician assistants, the requirement to provide to the insurance commissioner a closed claim report. A “closed claim” is one that has been settled, or otherwise disposed of, and for which the insurer has paid all claims. By law, the insurer must submit the report on a form the commissioner prescribes within 10 days after the last day of the calendar quarter in which a claim is closed. The report includes information only about claims settled under Connecticut law.

The act defines “medical professional” as any person licensed or certified to provide health care services to individuals, including chiropractors, clinical dietitians, clinical psychologists, dentists, nurses, occupational speech and physical therapists, optometrists, pharmacists, physicians, podiatrists, and psychiatric social workers. By law, a closed claim report contains details about the insured and the insurer, the injury or loss, the claims process, and the amount paid on each claim.

EFFECTIVE DATE: October 1, 2007

Closed Claim Reports

By law, the insurance commissioner must aggregate the individual closed claim report data into a summary and annual report. The summary must include (1) an analysis of the trend of direct losses, incurred losses, earned premiums, and investment income as compared to prior years and (2) base premiums medical malpractice insurers charge for each specialty and the number of providers insured by specialty for each insurer. By law, the commissioner must annually submit the report to the Insurance and Real Estate

Committee. He must also (1) make the report available to the public, (2) post it on the department's Internet site, and (3) provide public access to the electronic database after establishing that individually identifiable information about claimants and practitioners has been removed.

Claims Process

The report must contain details about the claims process including:

1. whether a lawsuit was filed and, if so, in which court;
2. its outcome;
3. the number of other defendants, if any;
4. the stage in the process when the claim was closed;
5. the trial dates;
6. the date of any judgment or settlement;
7. whether an appeal was filed and, if so, the date filed;
8. the resolution of the appeal and the date it was decided;
9. the date the claim was closed; and
10. the initial and final indemnity and expense reserve for the claim.

Amount Paid on the Claim

The report must include:

1. the total amount of the initial judgment rendered by a jury or awarded by the court;
2. the total amount of the settlement if no judgment was rendered or awarded or the claim was settled after judgment was rendered or awarded;
3. the amount of economic and noneconomic damages, or the insurer's estimate of these amounts in a settlement;
4. the amount of any interest awarded due to failure to accept an offer of compromise;
5. the amount of any reduction or addition and the amount of final judgment after such reductions or additions;
6. the amount the insurer paid;
7. the amount the defendant paid due to a deductible or a judgment or settlement in excess of policy limits;
8. the amount other insurers or defendants paid;
9. whether a structured settlement was used;
10. the expense assigned to and recorded with the claim, including defense and investigation costs but not including the actual claim payment; and
11. any other information the commissioner determines necessary to regulate the medical malpractice insurance industry, ensure its solvency, and ensure that such liability insurance is available and affordable.

Public Act 07-68 (House Bill 5286)

An Act Concerning Insurance on Residential Condominiums and Flood Insurance for Condominiums Located in Flood Hazard Areas

(Signed by Governor 5/30/2007)

For condominiums and other common interest communities governed by the Common Interest Ownership Act (CIOA), this act requires the association of unit owners to maintain flood insurance if (1) the property is located in a flood hazard area, as defined and determined by the National Flood Insurance Act and (2) the unit owners, by vote, require it. By law, common expenses for these common interest communities include the cost of repairing and replacing any portion of the common interest community that exceeds the insurance proceeds from the insurance the association must provide by law. The act specifies that common expenses also include any excess resulting from any applicable insurance deductible.

The act imposes similar requirements for condominiums governed by the Condominium Act. For these condominiums, the requirement applies only if the condominium instruments or unit owners' vote requires it. The act imposes this requirement on the association acting through its board of directors, managing agent, or other authorized agent. The Act requires, instead of authorizes, them to provide other types of insurance, including workers' compensation, directors' indemnity, and specialized policies covering lands or improvements in which the unit owners' association has or shares ownership or other rights, if the condominium instruments or unit owners' vote requires it.

Under prior law, premiums for insurance that the law requires the condominium associations governed by the Condominium Act to provide had to be treated as common expenses. This act allows the condominium instruments to instead assess the cost of the insurance coverage against the units in proportion to risk.

EFFECTIVE DATE: October 1, 2007

Background

CIOA, the Condominium Act, and the Unit Ownership Act

Three different sets of laws govern condominiums, depending on when they were created. CIOA governs the creation, alteration, management, termination, and sale of condominiums and other common interest communities formed in Connecticut after January 1, 1984 (CGS § 47-200 et seq.). The Condominium Act governs condominiums created from 1977 through 1983. (PA 76308; CGS §§ 47-68a to 47-90c). Condominiums created before the Condominium Act was adopted are governed by the Unit Ownership Act (PA 1963, No. 605, July 10, 1963; CGS §§ 47-67 to 47-115 Revised to 1975).

Certain CIOA provisions automatically apply to condominiums created in Connecticut before January 1, 1984, but only with respect to events and circumstances that occur after December 31, 1983. The CIOA insurance provisions amended by this act do not automatically apply to pre-CIOA condominiums (CGS § 47-216).

The law permits condominiums created before January 1, 1984 to amend their governing instruments (declaration, bylaws, survey, or plans) to conform to portions of CIOA that do not automatically apply. Thus, a pre-CIOA condominium may adopt any of these CIOA provisions it wishes and does not have to adopt all of CIOA. Any amendment must be

adopted in accordance with the law that applied when the condominium was created and with the procedures and requirements specified by the condominium's declaration and bylaws (CGS § 47-218).

Common Interest Community

“Common interest community” means real property described in a declaration on which a person, by virtue of his ownership of a unit, is obligated to make payments for (1) real property taxes, (2) insurance premiums, (3) maintenance, or (4) improvement of any other real property other than the unit described in the declaration (CGS § 47-202 (7)).

Related Law

For condominiums governed by CIOA, to the extent required by the declaration, associations must assess the costs of insurance in proportion to risk (CGS § 47-257 (c)).

Public Act 07-77 (House Bill 7300)

An Act Establishing Measures to Mitigate Catastrophic Losses due to Hurricanes and Severe Storms

(Signed by Governor 5/30/2007)

Effective July 1, 2007, this act prohibits an insurer from refusing to issue or renew a homeowners insurance policy solely because a person has not installed permanent storm shutters on his or her home to mitigate loss from hurricanes and severe storms. It requires an insurer to offer an actuarially sound premium discount to homeowners who install permanent storm shutters or impact-resistant glass for loss mitigation purposes.

The act authorizes the insurance commissioner to (1) establish and adopt regulations for a Coastal Market Assistance Program (CMAP) to help coastal-area residents obtain homeowners insurance and (2) require an insurer that does not issue or renew a homeowners policy to tell the homeowner about CMAP in writing. (The act does not define what it means to be “in proximity to the coastal area.”) The act includes certain owners of mobile homes as homeowners.

EFFECTIVE DATE: Upon passage, except for the insurer prohibition and premium discount provisions, which are effective January 1, 2008. (PA 07-4, June Special Session, changes the effective date of the insurer prohibition to July 1, 2007.)

Background

MOBILE HOMEOWNER

In applying its requirements, the act includes as a homeowner a person who owns and occupies a mobile dwelling that is (1) equipped for year-round living, (2) permanently attached to a foundation on property the person owns or leases, (3) connected to utilities, (4) assessed as real property for tax purposes, and (5) in conformance with state and local laws and ordinances.

CMAP

According to the act, CMAP's purpose is to help homeowners find insurance for residential dwellings located near the state's coastal area. The act permits CMAP to consist of a voluntary network of participating insurers and insurance producers that operates under the insurance commissioner's guidance. It permits the commissioner to adopt implementing regulations.

Coastal Area

In January 2007, the Insurance Department published administrative guidelines for underwriting coastal homeowners insurance policies. The guidelines differ if the insured property is within or over 2,600 feet of the coast. The department's publication, which is available on its web site, notes that there is no generally accepted definition of "coast" for property and casualty insurance purposes. In the guidelines, coast refers "only to a salt-water ocean, sound, bay, or inlet with the distance as measured from the median high water mark."

Public Act 07-167 (Senate Bill 1400)

An Act Concerning the Administration of the Department of Motor Vehicles (Signed by Governor 6/25/2007)

This act makes a number of changes to the Department of Motor Vehicles. Only those sections of interest to the Connecticut Insurance Department are summarized below.

Section 11 – INSURANCE REQUIREMENTS FOR MOTOR CARRIERS

The act expands insurance requirements for certain motor carriers. By law, owners of certain commercial motor vehicles must file evidence with the DMV commissioner every six months that they have the insurance coverage or other security required by law for each vehicle they operate. For those carriers subject to federal financial responsibility coverage requirements, the commissioner has adopted the same coverage levels as state requirements. The minimum federal financial responsibility limits generally apply to (1) for-hire carriers with gross vehicle weight ratings over 10,000 pounds carrying non-hazardous cargo in interstate commerce, (2) for-hire and private carriers in interstate or intrastate commerce carrying hazardous materials requiring warning placards under federal law, and (3) any vehicles carrying passengers for hire in interstate commerce.

The state applies the federal minimum levels of coverage for vehicles (1) engaged in intrastate commerce with gross vehicle weight ratings of 18,001 pounds or more; (2) engaged in interstate commerce with gross vehicle weight ratings of 10,001 pounds or more; (3) designed to transport more than 15 passengers, including the driver; and (4) used to transport hazardous materials requiring placards, regardless of vehicle size. Generally,

1. non-hazardous property carriers subject to federal limits must have a minimum of \$750,000 liability coverage;

2. hazardous materials carriers must have either \$1 million or \$5 million in liability coverage depending on the classification of the hazardous material carried; and
3. passenger carriers must have \$1. 5 million if the vehicle seats fewer than 15 passengers and \$5 million if it seats 16 or more.

The act requires that all for-hire carriers and private carriers of property or passengers, and the owner of any vehicle that transports hazardous material requiring warning placards under federal law show in their semiannual filings with DMV that they maintain the minimum level of financial responsibility the federal regulations specify. This appears to extend the higher federal, rather than state limits, to certain types of carriers (e. g., private carriers with over 10,000 pounds gross weight ratings carrying non-hazardous cargo in intrastate commerce or passenger carriers engaged in intrastate commerce, which, because they are not currently covered by the federal limits, may not have to show the same levels of financial responsibility as carriers that are explicitly under the federal regulations).

Section 31 – RECOVERY OF TOWING CHARGES BY TOWERS

Under prior law, when a tower removed a motor vehicle from the highway or from private property and brought it to its storage facility, the tower was granted a lien upon the vehicle for storage charges. The act expands this lien authority to include the towing charges as well as the storage charges. The lien is usually satisfied either by (1) the vehicle's owner if he or she comes to claim the vehicle or (2) the proceeds of any sale of the vehicle pursuant to the statutory requirements governing how towers may dispose of unclaimed vehicles.

EFFECTIVE DATE: October 1, 2007

Human Resources – Agency Operations – Other

Public Act 07-3 (House Bill 5706)

An Act Concerning Leave for State Employees Providing Disaster Relief

(Signed by Governor 4/25/2007)

This act gives a state employee who is a certified American Red Cross disaster service volunteer up to 15 working days each year, rather than 14 calendar days, to participate in Red Cross specialized disaster relief services without loss of pay or accrued leave time (vacation, sick, or earned overtime). By law, the leave must be (1) approved by the employee's supervisor and (2) requested by the Red Cross.

EFFECTIVE DATE: October 1, 2007

Public Act 07-27 (Senate Bill 1102)

An Act Requiring the Use of Generally Accepted Accounting Principles for Certain Audits

(Signed by Governor 5/18/2007)

This act permits the insurance commissioner to accept from certain “employers' mutual associations” financial statements that use generally accepted accounting procedures (GAAP) if the statement includes a conversion to statutory accounting procedures (SAP). The association must submit the financial statements quarterly and annually.

EFFECTIVE DATE: October 1, 2007

Background

EMPLOYERS' MUTUAL ASSOCIATION FINANCIAL STATEMENTS

The act permits the insurance commissioner to accept financial statements prepared using GAAP if the statements include a conversion to SAP from an employers' mutual association that (1) was organized before June 6, 1996, (2) is composed exclusively of health care providers, and (3) derives its premiums entirely from health care organizations. Annually by March 1, the association must submit to the commissioner a financial statement covering the preceding calendar year that:

1. is audited by an independent certified public accountant;
2. is prepared in a manner the commissioner prescribes;
3. is signed and sworn to by the association's president or vice president and secretary or assistant secretary; and
4. includes an actuary's or reserve specialist's certification of reserve liabilities prepared in accordance with Insurance Department regulations.

The association must also submit quarterly, unaudited financial statements using GAAP if the statements include a conversion to SAP.

Employers' Mutual Associations

An employers' mutual association is a mutual association formed by a group of employers in the same or similar trade or business with substantially similar degrees of risk of injury to employees to insure the employers' liabilities under the state Workers' Compensation Act. This is an alternative to the employers purchasing commercial insurance.

By law, the insurance commissioner has financial oversight of these associations and periodically conducts a financial examination of them following the statutorily prescribed standards applicable to licensed insurance companies.

Statutory Accounting Principles

Insurance companies prepare their financial statements using SAP, a set of accounting regulations the National Association of Insurance Commissioners developed. The SAP method of preparing financial statements is regarded as more conservative than the GAAP method.

Public Act 07-54 (House Bill 6982)

An Act Making Minor and Technical Changes to the Insurance Statutes

(Signed by Governor 5/22/2007)

This act makes technical, non-substantive revisions to the insurance statutes.

EFFECTIVE DATE: Upon passage

Public Act 07-112 (Senate Bill 1186)

An Act Concerning State Employees Serving in Operation Jump Start or Certain Other Operations

(Signed by Governor 6/11/2007)

This act extends (1) paid leave to state employees called by the president or governor to active service in "Operation Jump Start" at the border of the United States and Mexico and (2) health insurance coverage to such employees and their dependents. These employees get (1) full state pay for active-duty leave up to 30 days and (2) payment of the difference between their state pay (including longevity) and military pay after 30 days. These employees and their dependents continue to receive state health insurance coverage for the duration of the call-up as long as the employees continue to make their co-payments at pre-activation levels.

The law already provides these same benefits to state employees called to active service in (1) Operation Enduring Freedom (Afghanistan war), (2) Operation Noble Eagle (anti-terrorism activities within the United States), (3) any related military or emergency operation whose mission was substantially changed because of the September 11, 2001 terrorist attacks, (4) any federal or state action authorized by the governor to support Operation Liberty Shield or combat terrorism in the United States, and (5) military action

authorized by the president against Iraq. The act prohibits employers from denying benefits to state employees called to active service in the above conflicts solely because of any collective bargaining agreement classifying their leave as recess or other equivalent leave rather than vacation. These include bargaining agreements covering state employees in teaching, instructional, or professional positions in Unified School Districts 1, 2, or 3.

EFFECTIVE DATE: Upon passage

Background

EMPLOYEES CALLED TO ACTIVE SERVICE

By law, state employees called to active service during various wars and conflicts continue to accrue vacation time to which they would have been entitled had they continued working in their state jobs. The act specifies that they must continue to accrue equivalent leave, which it defines as leave classified as other than vacation or sick time, including recess. It specifies that employees must be credited with their accrued vacation time, equivalent leave time, and sick time. But if the accrued time would cause an employee to exceed any limit placed on leave by statutes, regulations, or collective bargaining agreement, the employer must waive the limit to allow the employee to use the excess leave before the last of the following:

1. from the date of the employee's discharge from active service until he or she returns to state employment,
2. not later than 120 calendar days after the employee returns to state employment, or
3. not later than 120 calendar days after the employee is credited with the excess leave time.

Public Act 07-181 (Senate Bill 1048)

An Act Concerning the Investigation of a Discrimination Complaint Against or by an Agency Head or State Commission or Board Member

(Signed by Governor 7/5/2007)

This act requires investigations of discrimination complaints made against or by a state agency head, a board or commission member, or an affirmative action officer (AAO) to be shifted to another agency.

By law, each state agency, department, board, or commission must designate an AAO. Prior law required the AAO to (1) investigate all discrimination complaints made against the entity and (2) report all the findings and recommendations to the entity's commissioner or director for proper action. Under the act, complaints against or by an agency head, board or commission member, or AAO must be referred to the Commission on Human Rights and Opportunities (CHRO) for review and, if appropriate, to the Department of Administrative Services (DAS) for investigation. Also, it requires that a discrimination complaint against CHRO be handled by DAS and a complaint against DAS be handled by CHRO.

EFFECTIVE DATE: Upon passage

Background

COMPLAINTS AGAINST OR BY AN AGENCY HEAD

The act requires all discrimination complaints made against or by an agency head, board or commission member, or AAO to be reviewed by CHRO and, if appropriate, referred to DAS for investigation. CHRO must refer the complaint to DAS for review and, if appropriate, investigation, when the complaint is made against or by CHRO's executive head, commission member, or AAO. If the discrimination complaint is made against or by the DAS commissioner or AAO, the act requires CHRO to review and investigate, if appropriate.

It also requires the person or entity investigating the complaint against an agency head, board or commission member, or AAO to report any findings to the entity or person that appointed the agency head or member. For example, when the complaint is against an agency commissioner, the findings must be reported to the governor. The act specifies that the new complaint provision applies to complaints pending on or after the act's passage.

NOTIFYING AGENCIES OF COMPLAINTS TO CHRO OR EEOC

By law, an AAO is barred from representing his or her own agency before CHRO or the federal Equal Employment Opportunities Commission in a complaint against the agency. The attorney general must handle the complaint. The act also requires the attorney general, or his designee, to provide the agency AAO with a copy of the complaint. The AAO must investigate the complaint as required by law.

The act requires the attorney general's designee to complete state and federal discrimination law and investigation training that CHRO and the Permanent Commission on the Status of Women conduct for all AAOs pursuant to law. The law requires a minimum of 10 hours of training the first year and a minimum of five hours each following year.

Public Act 07-213 (Senate Bill 1182)

An Act Concerning Administrative Procedures of the Department of Public Works, Auditing of Large Construction Contracts, Environmental Review of Certain Land Transfers, Grant Payments to Municipalities, Advertising on State Building and Certain Exemptions to the Freedom of Information Act
(Signed by Governor 7/10/2007)

This act makes several unrelated changes affecting:

1. state construction and contracts,
2. state real property,
3. the Freedom of Information Act (FOIA),
4. certain state grant payments to municipalities and neighborhood revitalization zones (NRZs), and

5. the comptroller.

Only those sections of the law of direct impact to the Connecticut Insurance Department are summarized below.

FREEDOM OF INFORMATION ACT §§ 22 AND 23

Exempt Records

The act makes changes to the public's access to records. It exempts from disclosure under FOIA (1) the name and address of any minor enrolled in any parks and recreation program administered or sponsored by a public agency and (2) certain documents created during the contract award process.

Concerning contract awards, the act exempts responses to public agency requests for proposals or bid solicitations, and any related record or file the agency creates, if the agency's chief executive officer certifies that the public interest in confidentiality outweighs the public interest in disclosure. The documents may remain confidential only until the contract is executed or negotiations have ended, whichever occurs first.

Public Meeting Notices

The act requires state agencies, other than the General Assembly, to file their regular meeting agendas with the secretary of the state. It requires local agencies to file their agendas with the town clerk or the clerk of a multi-town district or agency, whichever is applicable. By law, agencies must file notices at least 24 hours before the meetings.

The act requires state agencies and the secretary of the state to post the agendas on their websites but does not specify when the postings must occur.

The law, unchanged by the act, requires state and local agencies to file the agendas in their respective offices. Under prior law, they filed their agendas with the secretary of the state or the appropriate clerk only if they had no regular office or place of business. The General Assembly is exempt from the filing requirement.

EFFECTIVE DATE: Upon passage, except the DPW commissioner's authority to contract with consultants is effective July 1, 2007 and the provisions addressing (1) labor and material bonds, (2) the review of state property and the related account, and (3) FOIA are effective October 1, 2007.

Other Acts of Interest

Public Act 07-31 (Senate Bill 1378)

An Act Concerning the Workers' Compensation Medical Practitioners' Fee Schedule and Time for Filing a Workers' Compensation Appeal

(Signed by Governor 5/18/2007)

This act requires the Workers' Compensation Commission chairman, by April 1, 2008, to develop, implement, and annually update a new medical practitioners' fee schedule using values from the Medicare resource-based relative value scale (RBRVS). The Medicare RBRVS conversion must be revenue neutral to the workers' compensation system. The fee schedule is used as a basis for physician and other practitioner fees for services provided under the Workers' Compensation Act. The chairman must also implement coding guidelines that conform to the federal Centers for Medicare and Medicaid Services' Correct Coding Initiative. For services rendered under workers' compensation in cases where there is no established Medicare RBRVS, the act authorizes the chairman to make necessary adjustments to the fee schedule.

The act expands the list of people who can receive fees for service to include "other persons." By law, approved physicians, surgeons, podiatrists, optometrists, and dentists can receive fees under workers' compensation, but, in practice, other medical professionals also receive fees. The act also delays the start of the 20-day deadline to file an appeal of a workers' compensation award or order to the Compensation Review Board in situations when a ruling is pending on a subsequently filed motion. Under the act, the 20-day period to file an appeal with the board begins when a compensation commissioner rules on the motion. Under prior law, the 20-day period began when a commissioner issued an award or order, regardless of any subsequent motions.

EFFECTIVE DATE: October 1, 2007

Background

Medicare Resource-Based Relative Value Scale (RBRVS)

This scale ranks medical services according to the relative costs of resources needed to produce the services. Medicare uses three components to calculate resource costs (and therefore the relative value) of each medical service: (1) physician (or other provider) work, 55%; (2) practice expense, 42%; and (3) liability insurance, 3%. The total relative value of a particular medical service is multiplied by a conversion factor to determine the Medicare fee. The RBRVS method is familiar to and accepted by all physician practices because Medicare is the nation's largest medical services payer.

Public Act 07-80 (Senate Bill 1036)
An Act Concerning Notification to Injured Employees of the Discontinuation or Reduction of Workers' Compensation Benefits
(Signed by Governor 6/1/2007)

This act extends, from 10 to 15 days, the period during which an employee can request a hearing after receiving a workers' compensation benefit reduction or discontinuation notice. By law, the employee has the right to request such a hearing. If there is no request, benefits are automatically reduced or discontinued. The act also requires that certain additional information be included in the form notifying an employee of the pending reduction or discontinuation.

It also increases the maximum penalty, from \$500 to \$1,000, for an employer's or insurer's undue delay of a compensation payment due to such party's fault or neglect. The act permits the compensation commissioner hearing the claim to assess the penalty for each delay.

The act requires the penalty be paid to the claimant, but existing law requires all fines and penalties collected under this provision be paid to the treasurer and deposited in the Second Injury Fund.

It also makes a conforming change.

EFFECTIVE DATE: October 1, 2007

Background

NEW NOTIFICATION REQUIREMENTS

In addition to the existing notification requirements (such as stating the employee's name and employer) the act requires the notice to identify:

1. the employee's attorney or other representative;
2. the insurer;
3. the injury, its nature, and the date it occurred; and
4. the city or town in which the injury occurred.

(In practice, the prior form used by the Workers' Compensation Commission required this information.)

The notice must also include medical documentation that establishes the basis for discontinuing or reducing benefits and identifies the employee's attending physician. Under prior law, the employer had to state the reason for the reduction or discontinuation of benefits, and the "attending surgeon" had to sign the form and indicate what kind of work the employee could perform.

NEW REQUIRED LANGUAGE

The act requires that the notice form include the following statement:

"If you object to the reduction or discontinuation of benefits as stated in this notice, **YOU MUST REQUEST A HEARING NOT LATER THAN 15 DAYS** after your receipt of this notice, or this notice will automatically be approved."

Under prior law, the form had to state: “The employee may request a hearing by the compensation commissioner on the discontinuance or reduction set forth in this notice within 10 days of receipt of this notice. ” In addition, the new required language specifies that the employee (1) must call the workers' compensation district office handling the claim to request a hearing, (2) must be prepared to provide medical and other documentation to support the claim, and (3) should note the date the notice was received. This language was not required under prior law, although in practice the prior form advised employees to be prepared to provide medical documentation at the hearing to support their claim.

Public Act 07-89 (Senate Bill 931)

An Act Concerning Penalties for Concealing Employment or Other Information Related to Workers' Compensation Premiums

(Signed by Governor 6/5/2007)

This act authorizes the labor commissioner to issue a stop-work order to an employer who:

1. fails to obtain insurance or provide satisfactory proof of self-insurance for the employer's workers' compensation liability or
2. intends to injure, defraud, or deceive the employer's workers' compensation insurer by knowingly (a) misrepresenting an employee as an independent contractor (and thus not required to be covered by workers' compensation insurance) or (b) providing false, incomplete, or misleading information to the insurance company on the number of its employees in order to pay a lower premium.

By law, an employer who misrepresents the number of employees or provides misleading information is subject to (1) a class D felony (see Table on Penalties) and (2) a civil penalty from the Labor Department of \$300 for each violation. The act subjects an employer who fails to obtain insurance or self-insurance to these penalties. The law also subjects an employer who knowingly and willfully fails to obtain insurance or self-insurance to the penalties for a class D felony and civil penalties (see BACKGROUND for other penalties for these violations).

The act includes procedures for issuing and terminating stop-work orders, imposes penalties for violating stop-work orders, and requires the labor commissioner to adopt regulations to implement the act's stop-work order provisions.

EFFECTIVE DATE: October 1, 2007

Background

INVESTIGATIONS AND STOP-WORK ORDERS

Investigations

The law authorizes the labor commissioner to investigate complaints that an employer misrepresented an employee as an independent contractor or provided misleading information to the insurance company on the number of its employees in order to pay a lower premium. The law allows the commissioner to subpoena witnesses and records and

fine an employer or any officer or agent who hinders an investigation. Each day of a violation is a separate offense. The act increases the fine from between \$25 and \$100 to between \$100 and \$250.

The act applies these provisions to investigations of an employer's failure to obtain workers' compensation insurance or provide satisfactory proof of self-insurance.

Stop-Work Orders

The act requires the commissioner to issue a stop-work order within 72 hours after an investigation determines that the employer committed one of these violations. The stop-work order must require stopping all business operations but only for the specific place of business or employment for which the violation exists. The stop-work order is effective when served on the employer or at the place of business or employment. It can be served at a place of business or employment by posting a copy conspicuously at the location. The act requires the order to remain in effect until the commissioner orders it released on finding that the employer has complied with the workers' compensation requirement or after a hearing requested by the employer. The act allows the employer to request a hearing in writing within 10 days after the order is issued. The hearing is conducted according to the Uniform Administrative Procedures Act.

The act provides that the stop-work order and any penalties imposed under these provisions against a corporation, partnership, or sole proprietorship are effective against any successor entity that (1) is engaged in the same or an equivalent trade or activity and (2) has at least one of the same principals or officers.

Under the act, an employer who violates a stop-work order is liable to the Labor Department for a civil penalty of \$1,000 for each day of the violation.

Other Provisions on Investigations and Penalties for Violating Workers' Compensation Insurance and Self-Insurance Requirements

The law requires the state treasurer's investigations unit to investigate an employer for not complying with the insurance or self-insurance requirements at the request of the Second Injury Fund's custodian, the Workers' Compensation Commission, or a workers' compensation commissioner. The investigator issues a citation to require an employer in violation to meet the requirements and provide notice of a hearing and possible penalties. The commissioner conducts a hearing and if the employer is not in compliance, assesses a civil penalty. The commissioner assesses an additional penalty for each day the employer continues in non-compliance. Failure to pay within 90 days can result in a civil action to double the penalty.

An employer who knowingly and willfully fails to comply with the insurance and self-insurance requirements commits a class D felony. This applies to an owner of a sole proprietorship, a partner in a partnership, a principal in a limited liability company, or a corporate officer (CGS § 31-288(c) to (f)).

Public Act 07-130 (Senate Bill 1451)

An Act Establishing the Connecticut Homecare Option Program for the Elderly

(Signed by Governor 6/19/2007)

This act establishes a Connecticut Home Care Option Program for the Elderly and a Connecticut Home Care Trust Fund, administered by the state comptroller. The program and the fund must help people plan and save for the costs of certain elderly services that (1) are either not covered by a long-term health insurance policy or supplement services covered by such a policy or by Medicare and (2) will allow them to remain in their homes or live in a non-institutional setting as they age.

The act allows participants to establish individual savings accounts within the fund and allows an account's designated beneficiary to withdraw funds from it for qualified home care expenses. It exempts interest earned on fund accounts from the state income tax and makes any unspent funds remaining in an account when a beneficiary dies part of his or her estate.

The act specifies the comptroller's duties and authority over the program and the trust fund, establishes standards for investing the fund's assets and for offering the fund to investors, and creates a 19-member advisory committee for the program. Finally, the act eliminates the 250person limit on the number of participants in a state-funded pilot program that allows seniors to hire their own personal care assistance (PCA) attendants directly instead of going through a home health care agency.

EFFECTIVE DATE: October 1, 2007, except for the repeal of the PCA pilot program participation limit, which takes effect July 1, 2007. The income tax exemption applies to tax years starting on or after January 1, 2007.

QUALIFIED HOME CARE EXPENSES

The act allows home care program account beneficiaries to withdraw funds from an account to pay for "qualified home care expenses," which are expenses for instrumental activities of daily living, such as chore, homemaker, or companion services; adult day care; preparing meals; home-delivered meals; or transportation. They must be either (1) services performed by a Connecticut-licensed home care services provider, a homemaker or companion service registered with the Department of Consumer Protection, or a personal care assistant, or (2) licensed transportation services. They must also be recommended by a physician. Before a beneficiary can withdraw money from an account, a physician must certify to the fund that the beneficiary needs the qualified services to live independently in his or her home or another non-institutional setting.

INCOME TAX EXEMPTION

The act exempts interest a designated beneficiary earns on a home care program account from the state income tax. It does so by allowing the beneficiary to deduct any such interest includable in his or her federal adjusted gross income (AGI) when calculating his or her Connecticut AGI for state income tax purposes.

1. COMPTROLLER'S AUTHORITY AND DUTIES

On behalf and for the purposes of the fund, the act allows the comptroller to: receive and invest its money;

2. procure insurance for its assets and activities;
3. establish funds within the larger trust fund and maintain separate accounts for each beneficiary;
4. establish consistent terms for operating the trust, such as (a) ways of making contributions, (b) withdrawal, termination, and payment transfers (including to an eligible home care provider), (c) penalties for improper use of funds, (d) changing beneficiaries, and (e) administration charges or fees;
5. enter contractual agreements for services for the fund and pay for them with the fund's earnings;
6. apply for and receive public or private donations to enable the fund to achieve its objectives;
7. adopt regulations;
8. sue and be sued; and
9. take other necessary action to carry out the act's purposes or that is incidental to her duties under the act.

TRUST FUND INVESTMENTS

The act requires the comptroller to invest the fund in a reasonable way to achieve its objectives; exercise a prudent person's care and discretion; and consider such things as rate of return, risk, maturity, portfolio diversification, liquidity, projected disbursements and expenditures, and expected deposits and other gifts. The comptroller cannot require the fund to invest directly in Connecticut state or municipal bonds or other funds or investments (if any) she administers. She must keep fund assets continuously invested according to its objectives until they are (1) used by beneficiaries for qualified home care expenses, (2) used to pay the fund's operating expenses, or (3) returned to depositors and beneficiaries according to the participation agreement between the fund and its depositors.

FUND OFFERING AND SOLICITATION Under the act, fund material intended for distribution to prospective investors does not have to be filed, and fund investments do not have to be registered, with the banking commissioner. But the comptroller must get written advice from counsel, the Securities and Exchange Commission, or both, that the trust and participation in it are not subject to federal securities laws. The act promises that the state will not alter participants' rights until all the fund's obligations are discharged and contracts performed, unless the law makes adequate provision for their protection. It allows the trust to include this promise in its participation agreements and other contracts.

ADVISORY COMMITTEE The act establishes a 19-member advisory committee for the program consisting of a provider of home care services for the elderly and a physician specializing in geriatrics, both appointed by the governor, and the following officials or their designees:

1. the state treasurer, state comptroller, and social services commissioner;

2. a Commission on Aging representative;
3. the director of the long-term care partnership policy program within the Office of Policy and Management; and
4. the chairpersons and ranking members of the Human Services, Aging, and Finance, Revenue and Bonding committees.

The committee must meet at least once a year. The comptroller convenes the meetings.

Public Act 07-161 (Senate Bill 845)
An Act Concerning Survivor Benefits
(Signed by Governor 6/19/2007)

This act requires a municipality that provides survivor pension benefits for paid police and firefighters who die in the line of duty to continue to provide the benefits after the surviving spouse remarries. By law, total survivor benefits for paid police and firefighters include the workers' compensation survivor benefit plus the municipality's survivor benefit. The combined benefits cannot exceed 100% of the weekly pay that employees in the same position as the deceased employee receive during the compensable period. The act specifies that the combined weekly benefit cannot exceed 100% of the maximum rate for the same position. By law, workers' compensation survivor benefits end when the surviving spouse remarries or the dependent children reach 18.

EFFECTIVE DATE: October 1, 2007

Public Act 07-165 (Senate Bill 1270)
An Act Concerning Notice in Dram Shop Actions Involving Death or Incapacity and Manufacturer Permits for Brew Pubs
(Signed by Governor 6/25/2007)

Summary references to brew pubs have been deleted.

The Dram Shop Act makes a liquor seller liable if the seller or his or her employee sells liquor to an already intoxicated person who injures a person or property. An injured party has 120 days to notify the seller of an incident and his or her intention to sue for damages. This act extends the deadline for filing the notice to 180 days if the injured person dies or is incapacitated.

EFFECTIVE DATE: The Dram Shop Act provisions take effect July 1, 2007 and apply to causes of action arising on or after that date.

Background

Dram Shop Act

The Dram Shop Act does not require proof that the seller acted negligently. The maximum amount that can be recovered is \$250,000 for injuries to a single person or in aggregate for

injuries to more than one person. The court determines the actual amount of liability in a particular case.

Public Act 07-217 (House Bill 7409)

**An Act Concerning the Revisor's Technical Corrections to the General Statutes,
Expanding the Membership of the Sentencing Task Force and Revising Certain
Reporting Deadlines**

(Signed by Governor 7/12/2007)

This act makes a variety of technical, non-substantive corrections to the General Statutes. Changes in Sections 156 through Section 159 relate to the Insurance Statutes.