



CONNECTICUT INSURANCE DEPARTMENT

LEGISLATIVE SUMMARY

2009

**Connecticut Insurance Department
2009 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.*

ACTS PROPOSED BY THE INSURANCE DEPARTMENT.....1

Public Act 09-24 (House Bill 6356)
An Act Amending the Extended Warranty Statutes.....1

Public Act 09-48 (Senate Bill 764)
An Act Concerning Derivative Financial Transaction Controls.....2

Public Act 09-49 (Senate Bill 959)
An Act Concerning External Appeals of Adverse Determinations by a Managed Care Organization, Health Insurer, or Utilization Company.....3

ACTS OF DIRECT INTEREST TO THE INSURANCE DEPARTMENT..... 10

Life and Health..... 10

Public Act 09-46 (Senate Bill 46)
An Act Concerning the Consumer Report Card..... 10

Public Act 09-51 (House Bill 5023)
An Act Requiring Health Insurance Coverage for Wound Care for Individuals with Epidermolysis Bullosa..... 10

Public Act 09-115 (Senate Bill 301)
An Act Concerning Health Insurance Coverage for Autism Spectrum Disorders..... 11

Public Act 09-123 (House Bill 5019)
An Act Prohibiting the Use of Certain Prescription Drug History as an Underwriting Tool to Deny Individual Health Insurance Coverage..... 15

Public Act 09-124 (House Bill 5433)
An Act Clarifying Health Insurance Coverage for Stepchildren..... 15

Public Act 09-136 (House Bill 6540)
An Act Concerning Prescription Eye Drop Refills..... 17

<i>Public Act 09-179 (House Bill 5018)</i> An Act Concerning Reviews of Health Insurance Benefits Mandated in this State.....	17
<i>Public Act 09-216 (House Bill 6279)</i> An Act Concerning Accelerated Benefits of Life Insurance Policies.....	20
<i>Property and Casualty</i>	22
<i>Public Act 09-72 (Senate Bill 895)</i> An Act Concerning Notification of Underinsured Motorist Conversion Coverage and the Recovery of Collision Deductible in a Subrogation Action.....	22
<i>Public Act 09-88 (House Bill 5519)</i> An Act Concerning Workers' Compensation Premiums and Volunteer Ambulance Companies.....	23
<i>Public Act 09-98 (Senate Bill 212)</i> An Act Limiting Cancellation Fees for Automobile Insurance Policyholders who Cancel Their Policies Mid-Term.....	23
<i>Public Act 09-164 (House Bill 6447)</i> An Act Mitigating Fire Losses for Homeowners and Business Owners.....	24
<i>Public Act 09-217 (House Bill 6280)</i> An Act Extending the Sunset Date for Personal Risk Insurance Rate Filings.....	25
<i>Business Office/Consumer Services/Human Resources/Legal</i>	27
<i>Public Act 09-13 (Senate Bill 899)</i> An Act Implementing the Guarantee of Equal Protection Under the Constitution of the State for Same Sex Couples.....	27
<i>Public Act 09-19 (House Bill 5930)</i> An Act Requiring Small Business Impact Analyses for Proposed Regulations.....	27
<i>Public Act 09-70 (Senate Bill 710)</i> An Act Concerning Updates to the Family and Medical Leave Act.....	29
<i>Public Act 09-74 (Senate Bill 960)</i> An Act Concerning the Legislative Commissioners' Recommendations for Technical Revisions to the Insurance Statutes.....	31
<i>Public Act 09-126 (House Bill 5669)</i> An Act Concerning Employer Health Insurance Premium Payments for Terminated Employees.....	31

<i>Public Act 09-148 (House Bill 6600)</i> An Act Concerning the Establishment of the Sustinet Plan.....	33
<i>Public Act 09-158 (Senate Bill 1127)</i> An Act Concerning Certain State Contracting Nondiscrimination Requirements.....	34
<i>Public Act 09-174 (House Bill 6231)</i> An Act Concerning the Use of a Certificate, Professional Designation or Advertising in Advising Senior Citizens.....	36
<i>Public Act 09-204 (Senate Bill 47)</i> An Act Concerning Contracts Between Health Care Providers and Contracting Health Organizations.....	37
<i>Public Act 09-210 (Senate Bill 954)</i> An Act Concerning Personal Service Agreements, Purchase of Service Contracts and Nonemergency Medical Transportation Services.....	40
<i>Public Act 09-225 (House Bill 6672)</i> An Act Concerning the 2008 Amendments to the Uniform Common Interest Ownership Act.....	42
<i>Public Act 09-237 (Senate Bill 457)</i> An Act Concerning Motor Vehicle Repairs.....	43
<i>Public Act 09-240 (Senate Bill 894)</i> An Act Requiring Disclosure of Automobile Liability Insurance Policy Limits Prior to the Filing of a Claim.....	44
OTHER ACTS OF INTEREST.....	46
<i>Public Act 09-23 (House Bill 6327)</i> An Act Concerning Surety Bonds for Debt Adjusters.....	46
<i>Public Act 09-104 (Senate Bill 778)</i> An Act Concerning Evidence of Workers' Compensation Insurance for Contractors on Public Works Projects.....	46
<i>Public Act 09-122 (House Bill 6501)</i> An Act Eliminating Surety Bond Requirements for Residential Underground Heating Oil Tank Removal or Replacement Contractors.....	46

Public Act 09-134 (House Bill 6448)
An Act Concerning Disclosure of Insurance Requirements in Equipment Leases..... 47

Public Act 09-206 (Senate Bill 1048)
An Act Concerning Health Care Cost Control Initiatives..... 48

Public Act 09-222 (House Bill 6642)
An Act Concerning Solicitation of Clients, Patients or Customers.....49

Public Act 09-232 (House Bill 6678)
An Act Concerning Revisions to Department of Public Health Licensing Statute..... 51

Acts Proposed by the Insurance Department

Public Act 09-24 (House Bill 6356)

An Act Amending the Extended Warranty Statutes

(Signed by Governor 5/8/2009)

This act requires an insurer issuing an extended warranty reimbursement insurance policy in Connecticut to meet certain requirements when filing a policy form with the insurance commissioner and continuously thereafter. By law, insurers must file extended warranty insurance policies and endorsements with the insurance commissioner for his review prior to use.

Specifically, the act requires an extended warranty insurer to:

1. maintain surplus and paid-in capital of at least \$15 million;
2. demonstrate to the commissioner's satisfaction that it maintains a value of net written premiums that is no more than three times the amount of surplus and paid-in capital; and
3. annually file with the commissioner copies of (a) its audited financial statements, (b) the annual statement it files with the National Association of Insurance Commissioners, and (c) any actuarial certification that it must file with its domicile state.

The act is silent with respect to penalties should an insurer fail to comply with the new requirements.

EFFECTIVE DATE: October 1, 2009

BACKGROUND

Definitions

The law defines “extended warranty” as a contract or agreement to perform or indemnify a product's repair, replacement, or maintenance in case of an operational or structural failure that a defect in material, skill, or workmanship or normal wear and tear caused in exchange for a price separate from that charged for the product's lease or purchase price. An “extended warranty reimbursement insurance policy” is an insurance policy covering an extended warranty provider's obligations and liabilities under an extended warranty the provider sold.

An “extended warranty provider” is a person who (1) issues, makes, provides, or offers an extended warranty to a buyer and (2) is contractually obligated under the warranty to provide service. It excludes a retail seller if (1) the seller, or its subsidiary, manufactured the product the warranty covers; (2) the extended warranty it offers or sells obligates the manufacturer or its subsidiary, distributor, or importer to provide the service or indemnity the warranty requires; or (3) under the warranty's terms, the seller performs at least 90% of the repair service.

Extended Warranty

By law, an extended warranty cannot be issued, sold, or offered unless the extended warranty provider (1) is insured under an extended warranty reimbursement insurance policy an insurer authorized to do business in Connecticut issued or (2) can demonstrate that its claim reserves do not exceed 50% of its audited net worth. If they do, the provider must have an independent trustee hold the reserves in trust and an actuary annually certify their adequacy. The law does not apply to a home warranty contract or home warranty service agreement.

The law requires an extended warranty provider to file with the insurance commissioner a copy of its (1) extended warranty form and (2) extended warranty reimbursement insurance policy or certification from a certified public accountant attesting to the adequacy of its claim reserves.

Public Act 09-48 (Senate Bill 764) **An Act Concerning Derivative Financial Transaction Controls** *(Signed by Governor 5/20/2009)*

This act specifically allows a U. S. insurer doing business in Connecticut to enter into derivative financial transactions as long as it is prudent given the company's business and diversification considerations. This is, by law, the standard that generally applies to an insurer's investments. The act specifies that derivative financial transactions include swaps, options, forwards, futures, caps, floors, collars, and similar instruments or combinations of them.

The act requires an insurer entering into these transactions to include in its audited financial report a statement from the independent certified public accountant (CPA) who audited the insurer. The statement must describe the CPA's assessment of the insurer's internal controls relative to the transactions.

If the CPA determines the internal controls are deficient, the insurer must include with the statement (1) the CPA's report of the deficiencies and (2) a remedial action plan, if the CPA's statement does not include one. The remedial action plan must identify actions the insurer has taken or will take to correct the deficiencies.

By law, the insurance commissioner may adopt regulations he deems necessary to carry out the statutes on insurance company investments.

EFFECTIVE DATE: Upon passage

DEFINITIONS

Under the act, a “swap” is a contract to exchange, for a period of time, the investment performance of one underlying instrument for the investment performance of another

without exchanging the instruments themselves. An “option” is a contract that gives the purchaser the right, but not the obligation, to enter into a transaction with the seller for option rights on specified terms.

The act defines “forward” as a contract, other than a future, between two parties that commits one to purchase and the other to sell the instrument or commodity underlying the contract on a specified future date. A “future” is a standardized forward contract traded on a United States or qualified foreign exchange.

The act defines a “cap” as an option contract under which the seller, in return for a premium, agrees to limit the purchaser's risk associated with an increase in a reference rate or index. If the option contract is a “floor,” the seller agrees to limit the purchaser's risk associated with a decline in a reference rate or index. A “collar” is a contract with both a cap and a floor.

Public Act 09-49 (Senate Bill 959)
An Act Concerning External Appeals of Adverse Determinations by a Managed Care Organization, Health Insurer, or Utilization Company
(Signed by Governor 5/20/2009)

This act establishes an expedited external appeal process that supplements the legally required standard external appeal process. By law, a health plan enrollee, or a licensed health care provider acting on the enrollee's behalf with his or her consent (“provider”), must exhaust the internal appeal process of the health insurer, managed care organization (MCO), or utilization review (UR) company that made an adverse determination before applying to the insurance commissioner for a standard external appeal.

The act permits an enrollee or provider to ask the insurance commissioner for an expedited external appeal before exhausting the company's internal appeal process if (1) he or she has filed a request for an expedited internal review and (2) the time to complete it could cause, or exacerbate, an emergency or life-threatening situation for the enrollee. After receiving an expedited external appeal request, the required medical release, and a \$25 filing fee, the insurance commissioner must assign the appeal to an independent review entity.

The act adopts (1) standards, procedures, record maintenance, and reporting requirements for review entities and (2) qualifications for clinical reviewers. The review entities and their clinical reviewers decide whether to reverse, revise, or uphold a denial. The act makes a review entity's decisions regarding standard and expedited external appeals binding on the enrollee and the insurer, MCO, or UR company.

With respect to adverse determinations by a UR company, the act specifies that an

enrollee's provider of record, the licensed practitioner with primary responsibility for the enrollee's treatment, is deemed to be acting on the enrollee's behalf and with his or her consent if (1) the admission, service, procedure, or extension of stay in question has not yet occurred or (2) the entity's coverage denial creates a financial liability for the enrollee. It also makes technical and conforming changes.

EFFECTIVE DATE: October 1, 2009

DEFINITIONS

The act defines “adverse determination” as a decision by a health insurer, MCO, or UR company to deny, reduce, or terminate payment for an admission, service, procedure, or extension of stay that, although a covered benefit, does not meet its requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness. It defines a “covered benefit” as a service to which a health care plan enrollee is entitled under the terms of the plan. It defines “health care services” as services rendered to diagnose, prevent, treat, cure, or relieve a health condition, illness, injury, or disease. The act defines “review entity” as an entity that conducts independent, external reviews of adverse determinations. By law, review entities include (1) medical peer review organizations and independent UR companies that are not related to, or associated with, any insurer or MCO and (2) nationally recognized health experts or institutions the insurance commissioner approves.

A “managed care organization” (MCO) is an insurer, health care center (HMO), hospital or medical service corporation, or other organization delivering, issuing, renewing, amending, or continuing any individual or group health managed care plan in Connecticut.

EXPEDITED EXTERNAL APPEAL PROCESS

The act permits an enrollee or provider to ask the insurance commissioner for an expedited external appeal before exhausting the company's internal appeal process if (1) he or she has filed a request for an expedited internal review with the UR company and (2) the time to complete it could cause, or exacerbate, an emergency or life-threatening situation for the enrollee.

The request must include a \$25 filing fee and a signed medical records release form. The commissioner may waive the filing fee if the enrollee is indigent or unable to pay. The company against which the appeal is filed must also pay a \$25 fee. The commissioner must refund (1) the company's fee if, after a preliminary review, the appeal is not accepted for a full review or (2) the prevailing party's fee after a full review is completed.

Insurance Commissioner

Immediately upon receiving an expedited external appeal request, the act requires the commissioner to randomly assign it to a review entity from among the list of approved review entities established in accordance with the act. But the act prohibits the commissioner from granting an expedited external appeal if the enrollee has already received the health care services in question. It requires the commissioner to notify the insurer, MCO, or UR company that made the adverse determination of the (1) expedited external appeal request and (2) name of the assigned review entity.

Adverse Determination Information Required

The act requires the insurer, MCO, or UR company, within one business day after receiving the commissioner's notice, to provide the review entity all documents and information it considered in making the adverse determination. It may provide this information by e-mail, telephone, fax, or other expeditious method.

An MCO that fails to provide the required information on time is subject to a \$100 penalty for each day the information is late (CGS § 38a-478n).

Preliminary Review

Upon receiving the expedited external appeal from the commissioner, the act requires the review entity to conduct a preliminary review within two business days to determine whether to accept it for full review. (If the insurer, MCO, or UR company takes its full one business day to submit information, the entity has, in effect, one business day to complete the preliminary review.)

The review entity must accept the appeal for full review if it determines the:

1. patient involved is or was the involved health insurer's or MCO's enrollee;
2. benefit or service at issue reasonably appears to be a covered service or benefit under the health care plan;
3. enrollee or provider has provided all information the commissioner requires to make a preliminary determination, including the appeal form, a copy of the coverage denial, and a fully executed release to obtain any necessary medical records from the insurer, MCO, and any relevant provider; and
4. adverse determination may cause or exacerbate an emergency or life-threatening situation for the enrollee if the appeal is not reviewed expeditiously.

The review entity must, upon completing the preliminary review, immediately notify the enrollee or provider, as applicable, in writing whether or not the appeal is accepted for full review. If it is not accepted for full review, the written notification must include the reasons for the decision.

Denied Request for Expedited Appeal

The act permits an enrollee or provider to request a standard external appeal if an expedited external appeal request is denied.

Full Review

If the review entity accepts the appeal for full review, the act requires it to determine whether the coverage denial should be reversed, revised, or affirmed. Under the act, the person performing the review must be a health care provider specializing in the field related to the enrollee's condition.

Information to Consider

In conducting the full review, the review entity may consider:

1. pertinent medical records;
2. consulting reports from appropriate health care professionals;
3. documents the insurer, MCO, enrollee, the enrollee's authorized representative, or the enrollee's provider submitted;
4. practice guidelines the federal government or national, state, or local medical societies,

boards, or associations developed; and

5. clinical protocols or practice guidelines the MCO, insurer, or UR company developed. The act defines “authorized representative” as (1) a person to whom an enrollee gives express written consent to represent him or her in an external appeal, (2) a person the law authorizes to provide “substituted consent” for the enrollee, or (3) the enrollee's family member when the enrollee is unable to provide consent.

The act requires the review entity to consider, to the extent it is available and, in the review entity's opinion, appropriate, (1) the relevant health plan coverage terms to ensure the entity's decision does not conflict, (2) any applicable clinical review criteria the insurer, MCO, or UR company develops and uses in making adverse determinations, and (3) medical or scientific evidence. After considering that information, the act requires the review entity to also consider its own clinical reviewers' opinions.

The act defines “medical or scientific evidence” as evidence found in:

1. peer-reviewed scientific studies published in, or accepted for publication by, medical journals (a) meeting nationally recognized requirements for scientific manuscripts and (b) that submit most of their published articles for review by experts who are not part of the editorial staff;

2. peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus (MEDLINE) or Elsevier Science for indexing in Excerpta Medica (EMBASE);

3. medical journals the secretary of health and human services recognizes under federal Social Security law;

4. the following standard reference compendia: (a) the American Hospital Formulary Service - Drug Information, (b) Drug Facts and Comparisons, (c) the American Dental Association's Accepted Dental Therapeutics, and (d) the U. S. Pharmacopoeia - Drug Information; and

5. findings, studies, or research conducted by, or under the auspices of, federal government agencies or nationally recognized federal research institutes, including (a) the Agency for Healthcare Research and Quality, (b) the National Institutes of Health, (c) the National Cancer Institute, (d) the National Academy of Sciences, (e) the Centers for Medicare and Medicaid Services, (f) the Food and Drug Administration, (g) any national board the National Institutes of Health recognizes to evaluate the medical value of health care services, and (h) any other source comparable to (a) through (e).

Appeal Decision

The act requires the review entity to (1) complete the full review within two business days after the preliminary review is completed and (2) forward the commissioner its decision to reverse, revise, or affirm the adverse determination and a report of the full review.

The act permits the review entity to ask the commissioner for an extension to complete its review if circumstances exist beyond its control. If the commissioner grants the extension, the review entity must notify the enrollee or provider in writing of the (1) review status, (2) specific reasons for the delay, and (3) anticipated completion date.

The act specifies that a review entity is not bound by any decisions or conclusions the insurer, MCO, or UR company made during a utilization review process.

STANDARD EXTERNAL APPEAL

The act adds to the standard external appeal requirements. Specifically, when a review entity accepts a standard external appeal for full review, the act requires the commissioner to notify the insurer, MCO, or UR company that made the adverse determination of the (1) external appeal request and (2) name of the review entity assigned to the appeal.

Adverse Determination Information Required

The act requires the insurer, MCO, or UR company, within five business days after receiving the commissioner's notice, to provide the review entity all documents and information it considered in making the adverse determination. It may provide this information by e-mail, telephone, fax, or other expeditious method. By law, it must, within five days of receiving a request from the commissioner, provider, or enrollee, provide information regarding the benefit plan to which the appeal relates (e. g. , whether it is a fully- or self-insured plan, if the service to which the appeal relates is covered under the plan). By law, an MCO that fails to provide the required information on time is subject to a \$100 penalty for each day the information is late (CGS § 38a-478n).

BINDING DECISION

The act makes a review entity's external appeal decision—standard or expedited—binding on the insurer, MCO, UR company, and enrollee (but apparently not the provider). Prior law required the commissioner to accept the review entity's decision on a standard external appeal and made the commissioner's decision binding.

The act does not limit or prohibit any other remedy available under federal or state law.

SUBSEQUENT APPEAL PROHIBITED

The act prohibits an enrollee or provider from requesting a subsequent external appeal involving an adverse determination that was already the subject of an external appeal.

REVIEW ENTITIES

Under prior law, the insurance commissioner, after consulting with the public health commissioner, had to contract with impartial review entities to review appeals. The act requires him, instead, to contract with independent review entities that meet specified criteria.

Qualifications for Selection

Under the act, to be selected as a review entity, the entity must (1) hold approval or accreditation from a nationally recognized private accrediting review entity the commissioner approved or (2) demonstrate to the commissioner that it adheres to qualifications substantially similar to, and that do not provide less protection to enrollees than, the policies and procedures it must have in place if selected (see below).

The act requires each review entity to provide the commissioner a statement of qualifications in accordance with state and Insurance Department contracting

requirements. It deems as eligible a review entity accredited by a nationally recognized private accrediting review entity with independent review accreditation standards that the commissioner determines are at least equivalent to the minimum qualifications below. Under the act, the commissioner's approval of a review entity is effective for two years, unless he determines before the end of the two years that the review entity is not satisfying the minimum qualifications below, in which case he must terminate the entity's contract.

Written Policies and Procedures Required

The act requires each approved review entity to have and maintain written policies and procedures governing all aspects of the external appeal processes, including expedited appeals.

The review entity's policies and procedures must include a quality assurance mechanism ensuring that the entity:

1. conducts external appeals within the required time frames and provides required notices in a timely manner;
2. selects and employs a sufficient number of qualified, impartial clinical reviewers to conduct external appeals;
3. suitably assigns reviewers to specific cases;
4. maintains the confidentiality of medical and treatment records and clinical review criteria; and
5. ensures its employees and contractors comply with the act.

The review entity's policies and procedures also must include (1) a toll-free fax service or e-mail that can receive information related to external appeals 24-hours a day, seven days a week and (2) an agreement to maintain and provide to the commissioner specified information in accordance with the act's record-keeping and reporting requirements (see below).

Clinical Reviewers' Qualifications

The act requires each clinical reviewer that a review entity assigns to an external appeal to be a physician or other health care provider who is, at a minimum:

1. an expert in treating the medical condition that is the subject of the appeal;
2. knowledgeable about the recommended health care service or treatment through recent or current clinical experience treating patients with the same or similar condition;
3. holds a nonrestricted provider license in a U. S. state;
4. if a physician, currently certified by a recognized American medical specialty board in the area or areas appropriate to the subject of the external appeal; and
5. has no history of past or pending disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, by a hospital or governmental agency, unit, or regulatory body that raise a substantial question as to his or her physical, mental, or professional competence or moral character.

Conflict of Interest Prohibited

The act imposes conflict of interest restrictions for review entities. A review entity cannot own or control, be a subsidiary of, be owned or controlled by, or exercise control over, a health insurer; MCO; UR company; health plan; or a trade association of insurers, MCOs, or providers.

The act prohibits a review entity and its clinical reviewers assigned to appeals from having a “material professional, familial, or financial conflict of interest” with:

1. the insurer, MCO, or UR company that made the adverse determination being appealed or any of its officers, directors, or management employees;
2. the enrollee whose treatment is the subject of the appeal or the provider acting on his or her behalf;
3. the health care provider, medical group, or independent practice association recommending the service or treatment that is the subject of the appeal;
4. the facility or health care setting, including hospitals; licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitative or other therapeutic health settings, at which the service or treatment would be provided; or
5. the developer or manufacturer of the principal drug, device, procedure, or other therapy recommended for the enrollee whose treatment is the subject of the appeal.

When determining whether a review entity or clinical reviewer has a “material professional, familial, or financial conflict of interest,” the act requires the commissioner to consider situations in which the review entity or clinical reviewer may have an apparent relationship or connection, but the actual relationship or connection does not constitute a disqualifying material conflict of interest.

The act requires a review entity to (1) be unbiased and (2) establish and maintain written procedures to ensure such impartiality.

Immunity from Liability

The act specifies that no liability for damages accrues against a review entity or its clinical reviewer, employee, agent, or contractor, for an opinion rendered, or act or omission performed, within the entity's or person's duties relating to an external appeal conducted in accordance with the act, unless rendered or performed in bad faith or with gross negligence.

Record Retention

The act requires a review entity to maintain for at least six years written records of the external appeals it conducts. The records must be available for insurers', MCOs', or UR companies' review.

Reporting Requirements

The act requires a review entity, upon the commissioner's request, to report in a format he prescribes. The report must include, for each insurer, MCO, and UR company:

1. the number of requested standard and expedited external appeals;
2. the number of resolved appeals by disposition (reversed, revised, affirmed);
3. the length of time to resolve each appeal;
4. a summary of the procedure and diagnosis codes relating to appeals; and
5. any other information the commissioner requires.

Acts of Direct Interest to the Insurance Department

Life and Health

Public Act 09-46 (Senate Bill 46)
An Act Concerning the Consumer Report Card
(Signed by Governor 5/20/2009)

This act requires the (1) insurance commissioner to include in the annual health insurance consumer report card the medical loss ratio of each insurer and HMO included in the report and (2) Insurance Department to prominently display a link to the report card on its website. The act requires each health insurer or HMO to disclose its medical loss ratio, as reported in the most recent consumer report card, in writing to a person when he or she applies for coverage. (In effect, this provision only applies to HMOs and the 15 largest insurers that offer managed care plans in Connecticut, as these are the companies included in the report by law.)

The act defines “medical loss ratio” as the ratio of incurred claims to earned premiums for the prior calendar year for managed care plans issued in Connecticut. It limits “claims” to medical expenses for services and supplies provided to enrollees, excluding expenses for stop loss coverage, reinsurance, enrollee educational programs, and other cost containment programs or features. It also applies this definition to the laws requiring a managed care organization (MCO) to give certain information, including its medical loss ratio, to the commissioner and plan enrollees. Prior law described an MCO's medical loss ratio as the “percentage of the total premium revenue spent on medical care compared to administrative costs and plan marketing.”

The act names the report card the “Consumer Report Card on Health Insurance Carriers in Connecticut” and changes, from March 15 to October 15, the date by which the insurance commissioner, after consultation with the public health commissioner, must annually develop and distribute it.

EFFECTIVE DATE: October 1, 2009

BACKGROUND

The law defines an MCO as an insurer, HMO, hospital or medical service corporation, or other organization delivering, issuing, renewing, or amending individual or group health managed care plans in Connecticut.

Public Act 09-51 (House Bill 5023)
An Act Requiring Health Insurance Coverage for Wound Care for Individuals with Epidermolysis Bullosa
(Signed by Governor 5/21/2009)

This act requires certain insurance policies to cover wound care supplies that are medically necessary to treat epidermolysis bullosa and administered under a physician's direction.

The act applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on and after January 1, 2010 that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan. Due to federal law (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2010

BACKGROUND

Epidermolysis Bullosa

Epidermolysis bullosa (EB) refers to a group of rare skin diseases characterized by recurring blisters and open sores.

Medically Necessary

The law defines “medically necessary” as health care services that a physician, exercising prudent clinical judgment, would provide to a patient to prevent, evaluate, diagnose, or treat 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;
3. not primarily for the convenience of the patient, physician, or other health care provider; and
4. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results.

“Generally accepted standards of medical practice” means standards that are (1) based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or (2) otherwise consistent with the standards set forth in policy issues involving clinical judgment (CGS §§ 38a-482a and 38a-513c).

Public Act 09-115 (Senate Bill 301)

An Act Concerning Health Insurance Coverage for Autism Spectrum Disorders (Signed by Governor 6/9/2009)

This act requires a group health insurance policy to cover the diagnosis of autism spectrum disorders and expands the requirements on insurers to cover treatment of these disorders. It requires insurers to cover behavioral therapy for a child age 14 or younger and certain prescription drugs and psychiatric and psychological services for insureds with autism. The act permits a policy to set a certain annual dollar maximum for

behavioral therapy coverage. Prior law required a group health insurance policy to cover physical, speech, and occupational therapy services provided to treat autism to the same extent that it covers them for other diseases and conditions. The act removes that limitation, but specifies different conditions for covering the therapies.

The act authorizes an insurer, HMO, hospital or medical service corporation, or fraternal benefit society to review an autism treatment plan's outpatient services in accordance with its utilization review requirements, but not more often than once every six months, unless the insured's licensed physician, psychologist, or clinical social worker agrees a more frequent review is necessary or changes the insured's treatment plan.

The act specifies that it is not to be interpreted as limiting or affecting (1) other covered benefits under the policy, the state mental and nervous condition insurance law, and the birth-to three coverage law; (2) a board of education's obligation to provide services to an autistic student under an individualized education program in accordance with law; or (3) any obligation imposed on a public school by the federal Individual with Disabilities Education Act (20 USC § 1400).

The act also specifies that it must not be interpreted to require a group health insurance policy to reimburse special education and related services provided to an insured under state law that requires boards of education to provide special education programs and services unless state or federal law requires otherwise.

By law, each violation of the act is subject to a fine of up to \$1,000. The insurance commissioner may also revoke an out-of-state insurer's license for violating the act.

EFFECTIVE DATE: January 1, 2010

AUTISM SPECTRUM DISORDERS

The act defines “autism spectrum disorders” as the pervasive developmental disorders set forth in the most recent edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, including autistic disorders, Rett's disorder, childhood disintegrative disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

For purposes of its provisions and the definition of “medical necessity,” the act considers autism spectrum disorder an illness.

DIAGNOSIS

The act defines “diagnosis” as the medically necessary assessment, evaluation, or testing a licensed physician, psychologist, or clinical social worker performs to determine if a person has an autism spectrum disorder. It specifies that a diagnosis is valid for at least 12 months, unless a licensed physician, psychologist, or clinical social worker decides a shorter period is appropriate or changes the insured's diagnosis.

COVERAGE AND CONDITIONS

The act requires a group health insurance policy to cover:

1. behavioral therapy for children under age 15;
2. prescription drugs a licensed physician, physician assistant, or advanced practice registered nurse prescribes to treat autism spectrum disorder symptoms and co-morbidities (diseases or conditions existing together), to the extent the policy covers prescription drugs for other diseases and conditions;
3. direct and consultative psychiatric and psychological services; and
4. physical, speech, and occupational therapy services a licensed physical, speech and language, and occupational therapist provides, respectively.

Under the act, in order for the policy to cover these treatments, they must be (1) medically necessary, (2) identified and ordered by a licensed physician, psychologist, or clinical social worker for an insured person diagnosed with autism; and (3) based on a treatment plan. A licensed physician, psychologist, or clinical social worker must have developed the treatment plan following a comprehensive evaluation or reevaluation of the insured. The act allows the policy to limit the coverage for behavioral therapy to a yearly benefit of (1) \$50,000 for a child who is less than nine years of age, (2) \$35,000 for a child between nine and 13 years of age, and (3) \$25,000 for a child age 13 or 14. The act specifies that the coverage it requires may be subject to the other general exclusions and limitations of the group health insurance policy, including (1) coordination of benefits, (2) participating provider requirements, (3) restrictions on services provided by family or household members, and (4) case management provisions. But any utilization review must be performed in accordance with the act.

Behavioral Therapy

The act defines “behavioral therapy” as any interactive behavioral therapy derived from evidence-based research. It includes applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with an autism spectrum disorder that are (1) provided to children under age 15 and (2) provided or supervised by (a) a behavior analyst certified by the Behavior Analyst Certification Board, which is a nonprofit professional credentialing organization, (b) a licensed physician, or (c) a licensed psychologist. Supervision involves at least one hour of face-to-face supervision of the autism services provider for each 10 hours of behavioral therapy provided.

Applied Behavioral Analysis

The act defines “applied behavioral analysis” as designing, implementing, and evaluating environmental modifications using behavioral stimuli and consequences, including direct observation, measurement, and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in behavior.

COVERAGE PROHIBITIONS

The act prohibits a group health insurance policy from:

1. limiting the number of visits to an “autism services provider” (a person, entity, or group that provides treatment for autism spectrum disorders) on any basis other than a lack of medical necessity or

2. imposing a coinsurance, copayment, deductible, or other out-of-pocket expense that places a greater financial burden on an insured for access to the diagnosis and treatment of an autism spectrum disorder than for the diagnosis and treatment of any other medical, surgical, or physical health condition under the policy.

PENALTY

By law, an insurer, HMO, hospital or medical service corporation, or fraternal benefit society, or its officer or agent, that delivers or issues a policy that violates the act is subject to a fine of up to \$1,000 for each offense. The insurance commissioner may also revoke an out-of-state insurer's license for violating the act's provisions (CGS § 38a-548).

APPLICABILITY OF ACT

The act applies to group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan.

Due to federal law (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

BACKGROUND

The law defines “medically necessary” as health care services that a physician, exercising prudent clinical judgment, would provide to a patient to prevent, evaluate, diagnose, or treat 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;
3. not primarily for the convenience of the patient, physician, or other health care provider; and
4. and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results.

“Generally accepted standards of medical practice” means standards that are (1) based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or (2) otherwise consistent with the standards set forth in policy issues involving clinical judgment.

Related Laws

Mental or Nervous Conditions. Under Connecticut law, insurance must cover the diagnosis and treatment of mental or nervous conditions. It defines “mental or nervous conditions” as mental disorders, as it is used in the *Diagnostic and Statistical Manual of Mental Disorders*. It specifically excludes coverage for (1) mental retardation; (2) learning, motor skills, communication, and caffeine-related disorders; (3) relational

problems; and (4) additional conditions not otherwise defined as mental disorders in the DSM-IV-TR (CGS §§ 38a-488a and 38a-514).

Birth-to-Three. Insurance must cover medically necessary early intervention services for a child from birth until age three that are part of an individualized family service plan. Coverage is limited to \$3,200 per child per year, up to \$9,600 for the three years (CGS §§ 38a-490a and 38a-516a).

Public Act 09-123 (House Bill 5019)
An Act Prohibiting the Use of Certain Prescription Drug History as an Underwriting Tool to Deny Individual Health Insurance Coverage
(Signed by Governor 6/18/2009)

This act prohibits insurers or other entities in the individual health insurance market from using as an underwriting factor a person's history of taking a prescription drug for anxiety for six months or less. But it allows them to use such history if it arises directly from a medical diagnosis of an underlying condition.

The act applies to each insurer, HMO, hospital or medical service corporation, and fraternal benefit society that delivers, issues, renews, amends, or continues an individual health insurance policy in Connecticut.

By law, an insurer or entity cannot move an insured person from a standard underwriting classification to a substandard one after the policy is issued or increase premiums because of the person's claim experience or health status. The law allows for a premium increase that applies to all people in an underwriting classification as a whole.

By law, an insurer, HMO, hospital or medical service corporation, or fraternal benefit society, or its officer or agent, that delivers or issues a policy in Connecticut that violates the act is subject to a fine of up to \$10,000 for each offense. The insurance commissioner may also revoke the license of an out-of-state insurer or its agent for violating the act's provisions (CGS § 38a-506).

EFFECTIVE DATE: January 1, 2010

Public Act 09-124 (House Bill 5433)
An Act Clarifying Health Insurance Coverage for Stepchildren
(Signed by Governor 6/18/2009)

This act requires individual and group health insurance policies to cover stepchildren on the same basis as biological children.

It also extends the coverage eligibility law for individual health insurance policies to individual policies continued in Connecticut (i. e. , those in effect) that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; (4) limited benefits; (5) accidents only; and (6) hospital or medical services, including coverage under an HMO plan. Under the law, which already applies to individual policies delivered, issued, amended, or renewed in Connecticut, a child remains eligible for coverage until the policy anniversary date on or after the date the child (1) marries, (2) ends Connecticut residency, (3) becomes covered under his or her employer's group health plan, or (4) turns age 26, whichever occurs first. The residency requirement does not apply to a child who is under age 19 or a full-time student at an accredited college. Due to federal law (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: Upon passage

BACKGROUND

Insurance Coverage for Children

By law, an employee's unmarried children under age 26 are eligible to be covered under a group comprehensive health care plan (i. e. , a group plan with the minimum benefits all health insurers must offer) (CGS § 38a-554(a)).

The law also requires a group plan to offer a child whose coverage under the plan ends the option to remain covered until the end of the month in which the child (1) marries, (2) ends Connecticut residency, (3) becomes covered under his or her employer's group health plan, or (4) turns age 26, whichever provides the longest coverage period. The residency requirement does not apply to dependent children under age 19 or full-time students attending an accredited college. If the child elects this option, he or she may be required to pay the full premium and administrative costs, up to 102% of the full premium at the group rate (CGS § 38a-554(b)).

The law also prohibits individual and group policies from terminating a child's health coverage if, on the date his or her coverage eligibility would otherwise end, the child is (1) unmarried, (2) unable to work due to mental or physical handicap, and (3) dependent on the insured employee for support. The policyholder or employee must give the insurer proof of the child's handicap within 31 days of the date the child's coverage would otherwise end. The insurer may periodically require proof of continued incapacity and dependency (CGS §§ 38a-489, 38a-515, and 38a-554(b)).

Connecticut law also requires each group plan to provide for a right to convert to an individual policy when coverage under the group policy would otherwise cease (CGS § 38a-554(d)).

Public Act 09-136 (House Bill 6540)
An Act Concerning Prescription Eye Drop Refills
(Signed by Governor 6/18/2009)

This act prohibits certain health insurance policies that provide prescription eye drop coverage from denying coverage for prescription renewals when (1) the refill is requested by the insured less than 30 days from either (a) the date the original prescription was given to the insured or (b) the last date the prescription refill was given to the insured, whichever is later, and (2) the prescribing physician indicates on the original prescription that additional quantities are needed and the refill request does not exceed this amount.

The act applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2010 that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan.

Due to federal law (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2010

Public Act 09-179 (House Bill 5018)
An Act Concerning Reviews of Health Insurance Benefits Mandated in this State
(Signed by Governor 6/30/09)

This act establishes a health benefit review program in the Insurance Department to evaluate the social and financial impacts of “mandated health benefits” that (1) exist in statute or are effective on July 1, 2009 and (2) the Insurance and Real Estate Committee may request annually by August 1, including proposed legislation. In each case, the commissioner must report findings to the committee by the next January 1.

The act requires the commissioner to contract with the UConn Center for Public Health and Health Policy to conduct reviews the committee requests. It also authorizes him to assess insurers for the program's costs. Assessments must be deposited in the Insurance Fund.

EFFECTIVE DATE: July 1, 2009

MANDATED HEALTH BENEFIT REVIEW

The act requires the insurance commissioner to review mandated health benefits existing or effective on July 1, 2009 and report findings to the Insurance and Real Estate Committee by January 1, 2010. The act also requires the committee to give the commissioner, annually by August 1, a list of any mandated health benefits it wants reviewed. The commissioner must report the findings of the review to the committee by

the next January 1.

Definition

The act defines “mandated health benefit” as an existing statutory obligation of, or proposed legislation that would require, an insurer, HMO, hospital or medical service corporation, fraternal benefit society, or other entity offering health insurance or benefits in Connecticut to:

1. allow an insured or plan enrollee to obtain health care treatment or services from a particular type of health care provider;
2. offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; or
3. offer or provide coverage for (a) a particular type of health care treatment or service or (b) medical equipment, medical supplies, or drugs used in connection with a health care treatment or service.

The term includes proposed legislation to expand or repeal an existing health insurance or medical benefit statutory requirement.

UConn

The act requires the commissioner to contract with the UConn Center for Public Health and Health Policy to conduct reviews the Insurance and Real Estate committee requests. It authorizes the center's director, as he or she deems appropriate, to (1) retain an actuary, quality improvement clearinghouse, health policy research organization, or other independent expert and (2) engage or consult with any UConn dean, faculty, or other personnel, including those from the business, dental, law, medicine, and pharmacy schools.

Assessment

The act authorizes the commissioner to assess insurers for the program's costs. It specifies that the assessment is in addition to any other taxes, fees, and money the insurers pay to the state. The act requires the commissioner to deposit the paid assessments with the state treasurer, who must credit them to the Insurance Fund as expenses recovered from insurers. It authorizes the commissioner to spend such money to carry out the act's provisions.

Review Report Requirements

Social Impact. The report must include, to the extent available, the social impact of mandating the benefit, including:

1. the extent to which a significant portion of the population uses the treatment, service, equipment, supplies, or drugs;
2. the extent to which the treatment, service, or equipment is, or supplies and drugs are, available under Medicare or through public programs that charities, public schools, the Department of Public Health, municipal health departments or districts, or the Department of Social Services administer;
3. the extent to which insurance policies already cover the treatment, service, equipment, supplies, or drugs;
4. if coverage is not generally available, the extent to which this results in (a) people

being unable to obtain necessary treatment and (b) unreasonable financial hardships on those needing treatment;

5. the level of demand from the public and health care providers for (a) the treatment, service, equipment, supplies, or drugs and (b) insurance coverage for these;
6. the likelihood of meeting a consumer need based on other states' experiences;
7. relevant findings of state agencies or other appropriate public organizations relating to the benefit's social impact;
8. alternatives to meeting the identified need, including other treatments, methods, or procedures;
9. whether the benefit is (a) a medical or broader social need and (b) consistent with the role of health insurance and managed care concepts;
10. potential social implications regarding the direct or specific creation of a comparable mandated benefit for similar diseases, illnesses, or conditions;
11. the benefit's impact (a) on the availability of other benefits already offered and (b) on employers shifting to self-insured plans;
12. the extent to which employers with self-insured plans offer the benefit;
13. the impact of applying the benefit to the state employees' health plan; and
14. the extent to which credible scientific evidence published in peer-reviewed medical literature that the relevant medical community generally recognizes determines the treatment, service, equipment, supplies, or drugs are safe and effective.

Financial Impact.

The report must include, to the extent available, the financial impact of mandating the benefit, including:

1. the extent to which the benefit may increase or decrease, over the next five years, (a) the cost of the treatment, service, equipment, supplies, or drugs and (b) the appropriate or inappropriate use of the benefit;
2. the extent to which the treatment, service, or equipment is, or supplies or drugs are, more or less expensive than another that is determined to be equally safe and effective by credible scientific evidence published in peer-reviewed medical literature that the relevant medical community generally recognizes;
3. the extent to which the treatment, service, equipment, supplies, or drugs could be an alternative for a more or less expensive one;
4. the reasonably expected increase or decrease of a policyholder's insurance premiums and administrative expenses;
5. methods that will be implemented to manage the benefit's utilization and costs;
6. the impact on the (a) the total cost of health care, including potential savings to insurers and employers resulting from prevention or early detection of disease or illness and (b) cost of health care for small employers and other employers; and
7. the impact on (a) cost-shifting between private and public payors of health care coverage and (b) the overall cost of the state's health care delivery system.

Public Act 09-216 (House Bill 6279)
An Act Concerning Accelerated Benefits of Life Insurance Policies
(Signed by Governor 7/8/2009)

This act expands what constitutes a “qualifying event” for purposes of receiving an accelerated death benefit payment under a life insurance policy. By law, life insurers and fraternal benefit societies may include an accelerated benefit option in life insurance policies. The option pays benefits during an insured person's life upon the occurrence of a qualifying event, reducing the insurance benefit payable upon death.

The act (1) allows an insured person to collect the benefit when he or she is confined at home or in an acute care hospital, in addition to other institutions already allowed by law, due to a medically determinable condition; (2) eliminates a requirement that a licensed or certified health care provider render the person's care; and (3) specifies that the medically determinable condition that results in the insured's confinement must have resulted in the person being deemed chronically ill for the purposes of federal Internal Revenue Code. The act allows insurers to pay accelerated benefits due to confinement in lump sum or periodic payments, instead of only in a lump sum as under prior law.

By law, the insurance commissioner may adopt regulations necessary to implement the accelerated death benefit statutes. The act specifically authorizes him to address, in any such regulations, medically determinable conditions that are considered qualifying events.

EFFECTIVE DATE: January 1, 2010

DEFINITION OF QUALIFYING EVENT

Prior law defined a “qualifying event” as a:

1. medically determinable condition, such as coronary artery disease, myocardial infarction, stroke, kidney failure, or liver disease, that can be expected to result in death within about 12 months;
2. medical condition that would result in death within about 12 months in the absence of extensive or extraordinary medical treatment; or
3. medically determinable condition that has caused the insured person to be confined for at least six months in an institution other than an acute care hospital where he or she receives necessary care and treatment for an injury, illness, or loss of functional capacity from a certified or licensed health care provider, where it has been medically determined that he or she is expected to remain confined until death.

The act leaves intact the first two parts of the “qualifying event” definition, but it changes the third part to a medically determinable condition that has caused the insured person to be (1) considered a “chronically ill individual” for purposes of the federal Internal Revenue Code and (2) confined for at least six months in his or her place of residence or in an institution that provides necessary care and treatment of an injury, illness, or loss of functional capacity, where it has been medically determined that he or she is expected to remain confined until death.

Chronically Ill Individuals

Internal Revenue Code § 101(g) refers to the definition of “chronically ill individual” given in I. R. C. § 7702B(c)(2), excluding terminally ill individuals. I. R. C. § 7702B(c)(2) defines a “chronically ill individual” as a person whom a licensed health care practitioner certifies as (1) being unable to perform, without substantial assistance from another individual, at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity, or a similar level of disability as determined under regulations, or (2) requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment. A licensed health care practitioner must have certified within the preceding 12 months that the individual meets the requirements. Activities of daily living include eating, toileting, transferring, bathing, dressing, and continence.

Acts of Direct Interest to the Insurance Department

Property and Casualty

Public Act 09-72 (Senate Bill 895)

An Act Concerning Notification of Underinsured Motorist Conversion Coverage and the Recovery of Collision Deductible in a Subrogation Action (Signed by Governor 5/27/2009)

This act requires an auto insurer issuing a new automobile liability insurance policy to disclose to an insured at the time of sale or issuance the availability of, premium for, and description of underinsured motorist conversion coverage. The description must be made in a conspicuous manner with the legally required informed consent form regarding uninsured and underinsured motorist coverage.

Under the act, an auto insurer that subrogates a claim must (1) seek to recover any collision deductible the insured paid, unless the insured requests that it not be included in the subrogation demand, and (2) share subrogation recoveries with the insured on a proportionate basis. By law, an insurer providing underinsured motorist coverage cannot subrogate against the owner or operator of the underinsured motor vehicle for underinsured motorist benefits paid or payable by the insurer.

EFFECTIVE DATE: January 1, 2010

BACKGROUND

Minimum Coverage Required

The law requires each auto insurer to provide uninsured and underinsured motorist coverage with bodily injury and death limits equal to the liability limits the insured purchased, unless the insured (1) requests a lesser amount (but not below the legal limit) in writing and (2) signs an informed consent form. A person must purchase coverage of at least \$20,000 (for injury or death of one person) and \$40,000 (for more than one person in an accident).

Must Offer Coverage

By law, each auto insurer must offer, for an additional premium, underinsured motorist conversion coverage. If purchased, an insurer cannot reduce the insured's underinsured motorist coverage limit by amounts received from a tortfeasor or third-party on the insured's behalf.

Subrogation

Subrogation is the principle that gives an insurer who pays a claim the insured's rights and remedies against a third party with respect to that claim. Thus, if an insurer pays a claim for which another was liable, the insurer may seek payment from the liable party.

Public Act 09-88 (House Bill 5519)

An Act Concerning Workers' Compensation Premiums and Volunteer Ambulance Companies

(Signed by Governor 6/2/2009)

This act requires the state-licensed workers' compensation risk rating organization to file with the insurance commissioner, by October 1, 2009, a method of computing workers' compensation premiums for volunteer staff of municipal or volunteer ambulance services that does not base the premium primarily on the number of ambulances the service owns. The premium must be based primarily on ambulance usage as determined by the estimated annual number of service call responses. The new premium calculation applies to workers' compensation policies issued or renewed on or after October 1, 2009.

The act defines a municipal or volunteer ambulance service as a volunteer organization or municipality that the public health commissioner licenses to transport patients.

EFFECTIVE DATE: Upon passage

BACKGROUND

The National Council on Compensation Insurance (NCCI) is the private, state-licensed workers' compensation insurance rating organization that provides the state with advisory risk rating and actuary information. The insurance commissioner adopts annual risk rating and loss cost estimates from NCCI and insurance carriers use this information to develop workers' compensation premium rates for the voluntary market. The commissioner also adopts NCCI rate recommendations to establish premiums for the assigned risk plan market (a. k. a. "risk pool").

Public Act 09-98 (Senate Bill 212)

An Act Limiting Cancellation Fees for Automobile Insurance Policyholders who Cancel Their Policies Mid-Term

(Signed by Governor 6/2/2009)

This act prohibits an insurer that renews, amends, or endorses a private passenger automobile insurance policy in Connecticut from charging the insured more than \$100 for canceling the policy before the policy term ends. It also makes technical changes.

By law, any person or corporation that violates any insurance law that does not have a specific penalty is subject to a fine of up to \$15,000.

EFFECTIVE DATE: October 1, 2009

Public Act 09-164 (House Bill 6447)
An Act Mitigating Fire Losses for Homeowners and Business Owners
(Signed by Governor 6/30/2009)

This act makes numerous changes to the standard fire insurance policy that insurers, by law, must write in Connecticut. Specifically, it shortens the time an insurer has to pay a claim from 60 to 30 days and increases the statute of limitations for filing a lawsuit relating to a claim from 12 to 18 months after sustaining a loss. Additionally, the act allows an insured person and the insurer to agree in writing to a partial claim payment in advance of final claim adjudication and requires an insurer to reduce the total amount due to an insured by the amount of any advance partial payment made. The act specifies that an advanced partial payment does not affect the 30-day time period for total payment.

Under prior law, commercial risk insurance policies, including those issued to a condominium association, could exclude coverage for losses caused, directly or indirectly, by terrorism (1) if the premiums charged for the policy reflect projected savings from the exclusion and (2) until the terrorism risk program established under federal law expires. The act instead requires a condominium association's master insurance policy to include coverage for losses caused by terrorism if the condominium was formed after 1976. It still permits other commercial risk insurance policies, including those issued to a condominium formed before 1977, to exclude the coverage, subject to the two conditions. (The law allows the insurance commissioner to define "terrorism." He has adopted the definition used in the 2007 federal law reauthorizing the federal program.)

EFFECTIVE DATE: October 1, 2009

TERRORISM COVERAGE

The act requires a condominium association's master policy to include coverage for terrorism if the condominium is subject to the Common Interest Ownership Act (CIOA) or the Condominium Act. If the condominium is subject to the Unit Ownership Act, it may exclude such coverage, subject to the conditions specified in the law.

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 December 31, 1983 (CGS § 47-200 et seq.). The Condominium Act governs condominiums created from 1977 through 1983 (PA 76-308; CGS §§ 47-68a to 47-90c). The Unit Ownership Act governs condominiums created before 1977 (PA 1963, No. 605, July 10, 1963; CGS §§ 47-67 to 47-115 Rev. to 1975).

BACKGROUND

Federal Terrorism Risk Insurance Act

The 2002 federal Terrorism Risk Insurance Act created a temporary program under which the federal government shares the risk of loss from foreign terrorist attacks with the insurance industry. The 2007 Terrorism Risk Insurance Program Reauthorization Act

revised several provisions of the initial act and extended the program until December 31, 2014.

The act defines “act of terrorism” as an act the treasury secretary certifies, in concurrence with the secretary of state and U. S. attorney general, to:

1. be an act of terrorism;
2. be violent or dangerous to human life, property, or infrastructure;
3. have resulted in damage within the United States (or outside the United States in the case of certain air carriers, vessels, or U. S. missions); and
4. have been committed as part of an effort to coerce U. S. civilians or to influence the policy or affect the conduct of the U. S. government by coercion.

An act will not be certified as an act of terrorism if (1) aggregate property and casualty insurance losses resulting from the event do not exceed \$100 million or (2) it is committed in the course of a war declared by Congress. (This latter exclusion does not apply to workers' compensation claims.) The federal payout under the program is capped at \$100 billion.

The act requires insurers to offer coverage for losses caused by terrorism to all commercial insureds at the initial policy offer and at renewal. It prohibits the coverage from differing materially from the terms, amounts, and other limitations applicable to losses arising from non-terrorist acts.

The act requires insurers to give policyholders a disclosure containing specified information, including the amount of premium charged for losses caused by terrorism. If a policyholder does not pay the premium allocated for terrorism coverage, the policy will not take effect.

Public Act 09-217 (House Bill 6280)
An Act Extending the Sunset Date for Personal Risk Insurance Rate Filings
(Signed by Governor 7/8/2009)

This act extends the sunset date for the “flex rating” law for personal risk insurance (e.g., home, auto, marine, umbrella) from July 1, 2009 to July 1, 2011.

EFFECTIVE DATE: Upon passage

BACKGROUND

Flex Rating Law

The flex rating law permits property and casualty insurers, until the law sunsets, to file new personal risk insurance rates with the insurance commissioner and begin using them immediately without his prior approval if the rates increase or decrease by no more than 6% for all products included in the filing. The new rate cannot apply on an individual

basis. The law does not apply to rates for the residual market.

The law provides that an insurer may not submit more than one rate filing using the 6% band to the Insurance Department in any 12-month period, unless all rate filings submitted within the 12 months, in combination, do not result in a statewide rate change of plus or minus 6% for all products included in the filing.

Under the law, an insurer can apply a rate increase within the 6% band only on or after a policy renewal and after notifying the insured. (The notification specifies the effective date of the increase.) Rate filings requesting to increase or decrease rates by more than 6% must follow existing rate filing requirements (i.e., insurers must receive approval from the department before using such new rates).

The law deems that any filings made under its provisions comply with the rating laws, except that the commissioner is authorized to determine whether they are inadequate or unfairly discriminatory. It requires the commissioner to order the insurer to stop using a rate change within the 6% band on a specified future date if he determines it is inadequate or unfairly discriminatory. The order must be in writing and explain the finding. If the commissioner issues the order more than 30 days after the insurer submitted the filing to him, the law requires the order to apply prospectively only and not affect any contract issued before its effective date.

Acts of Direct Interest to the Insurance Department

Business Office/Consumer Services/Human Resources/Legal

Public Act 09-13 (Senate Bill 899)

An Act Implementing the Guarantee of Equal Protection Under the Constitution of the State for Same Sex Couples

(Signed by Governor 4/23/2009)

(NOTE: See Insurance Department Bulletin IC-21 revised, for the definition of spouse under insurance policies.)

This law redefines “marriage” as the legal union of two persons. On October 1, 2010, it transforms civil unions into marriages unless they have been annulled or the couple has divorced or is in the process of dissolving their relationship. It exempts clergy; churches; and IRS-qualified, church-controlled organizations from officiating or participating in a marriage ceremony that violates their religious freedom or beliefs.

The bill also repeals provisions in current law that:

1. declare that the current public policy of the state is limited to marriage between a man and a woman and
2. define marriage as the union of one man and one woman.

It establishes a rule controlling when marriages or substantially similar relationships formed in other jurisdictions must be recognized in Connecticut and gives other jurisdictions the discretion to recognize marriages and substantially similar relationships formed in Connecticut. Many of the bill's provisions conform statutes to the Connecticut Supreme Court's decision in *Kerrigan v. Dept. of Public Health*, which held that it was unconstitutional to restrict marriage to a man and a woman.

It also makes minor, technical, and conforming changes.

EFFECTIVE DATE: Upon passage, except the repeal of the civil union statutes and some conforming provisions are effective October 1, 2010.

Public Act 09-19 (House Bill 5930)

An Act Requiring Small Business Impact Analyses for Proposed Regulations

(Signed by Governor 5/8/2009)

This act requires any state agency proposing a regulation to identify how it affects small businesses (i.e., small business impact analysis) and include the analysis as part of the fiscal note it must submit to the Regulations Review Committee. The law already requires agencies to determine if a proposed regulation adversely affects small

businesses, which the act redefines as those employing 75 rather than 50 employees, and, if it does, to consider other less burdensome ways to achieve the regulation's goal (i.e., regulatory flexibility analysis). The act does not define "small business" for the small business impact analysis.

Before adopting a regulation, the act requires agencies to notify the public about how to obtain copies of the small business impact and regulatory flexibility analyses. The agencies must also notify the Commerce Committee about the regulation if they believe it could adversely affect small businesses, and the committee must help agencies prepare the flexibility analysis. Agencies must already notify the Department of Economic and Community Development about proposed regulations that could adversely affect small businesses, and the department must help them prepare the analysis.

Under the act, a proposed regulation does not take effect until the agency submits the regulatory flexibility analysis to the Regulations Review Committee. The law already specifies that the regulation does not take effect until the agency gives the committee the original proposed regulation, as approved by the attorney general, and 18 copies.

EFFECTIVE DATE: October 1, 2009

SMALL BUSINESS IMPACT ANALYSIS

Scope

By law, agencies must prepare and attach a fiscal note to a proposed regulation when they submit it to the Regulations Review Committee. The fiscal note must include the regulation's cost and revenue impact on the state or any municipalities. The act requires agencies to prepare the fiscal note either before or at the same time as, rather than after, publishing the regulation's public notice. It also requires that the fiscal note include an estimate of the regulation's cost or revenue impact on the state's small businesses, including the (1) estimated number of small businesses that would have to comply with the regulation and (2) how much it would cost them to do so. Costs include reporting, recordkeeping, and administration. The law already requires the agency to include the regulatory flexibility analysis in the fiscal note, which it must also submit to the committee.

Public Notice

The act requires agencies to inform the public about how it can obtain copies of the small business impact and regulatory flexibility analyses before adopting a regulation. (The act contains an incorrect statutory reference regarding the small business impact analyses.) They must include this information in the notice advising the public of their intent to adopt regulations. By law, agencies must publish this notice in the *Connecticut Law Journal* at least 30 days before adopting a regulation.

REGULATORY FLEXIBILITY ANALYSES

The law requires agencies to determine if a proposed regulation adversely affects small businesses and, if it does, to prepare a regulatory flexibility analysis to consider ways to

minimize the impact and still accomplish the regulation's purpose without compromising public health, safety, and welfare. The act specifies that the regulatory methods must be consistent with public health, safety, and welfare. And it makes a technical change. The act requires agencies to include the regulatory flexibility analysis in the regulation's official record. By law, agencies do not have to prepare regulatory flexibility analyses for emergency regulations, those indirectly affecting small businesses, or certain other types of regulations.

Small Business Definition

Under prior law, independently owned and operated businesses with fewer than 50 full-time employees or gross sales under \$5 million were considered small businesses. The act increases this threshold to 75 employees. By law, agencies may set a higher full-time employee threshold if necessary to meet or address specific small business needs and concerns. The limit cannot exceed the applicable federal standard or 500 employees, whichever is less.

Public Act 09-70 (Senate Bill 710)

An Act Concerning Updates to the Family and Medical Leave Act (Signed by Governor 5/27/2009)

This act permits an employee to take unpaid family and medical leave (FML) to care for an immediate family member or next of kin who is a current member of the U. S. military, National Guard, or the reserves with a serious illness or injury received in the line of duty. The employee may take up to 26 weeks of unpaid leave if the family member is:

1. undergoing medical treatment, recuperation, or therapy;
2. otherwise in outpatient status; or
3. on the temporary disability retired list for a serious injury or illness.

The act provides for 26 weeks of leave over a 12-month period under the private-sector FML law and 26 weeks of leave over a two-year period under the state-employee law. Under both private and state employee provisions, the employee's leave is permitted for a related armed forces member per serious injury or illness incurred in the line of duty. Under the private-sector law, the 12-month period begins on the first day of military caregiver leave.

The act incorporates the new military caregiver leave into existing provisions of FML laws for private sector and state employees regarding written certification of medical need, intermittent leave, and other items. The act specifies that leave taken pursuant to private-sector FML does not run concurrently with a transfer to "light duty" work in lieu of regular work duties under the Workers' Compensation Act.

EFFECTIVE DATE: Upon passage

MILITARY CAREGIVER LEAVE

Eligibility and Definitions

The act sets conditions under which a spouse, son or daughter, parent, or next of kin may take unpaid military caregiver leave under state FML law. It allows them to do so if the immediate family member or next of kin is a member of the Army, Navy, Marine Corps, Coast Guard, and Air Force and any reserve component, including the Connecticut National Guard performing duty as provided under federal law (CGS § 27-103).

It also defines “son or daughter” as a biological, adopted, foster child, stepchild, legal ward, or a child for whom the eligible employee or armed forces member stood in loco parentis and who is any age.

It defines “next of kin” as the service member's nearest blood relative, other than his or her spouse, parent, or child, in the following order of priority:

1. blood relatives who have been granted legal custody of the service member by court decree or statutory provisions,
2. siblings,
3. grandparents,
4. aunts and uncles, and
5. first cousins.

If the service member has designated in writing another blood relative as his or her nearest blood relative for purposes of military caregiver leave, then the designated individual must be deemed the member's next of kin.

Job Protection for Military Leave Caregivers

As with employees taking leave under the existing family and medical leave laws, the act requires the employer to restore the military caregiver to his or her previous position or an equivalent one.

Conditions or Requirements for Military Caregiver Leave

Private-Sector FML Changes. Military caregivers are treated, for the most part, like other employees taking unpaid leave under the existing private-sector FML. This means:

1. an eligible employee may elect or eligible employer may require the employee to substitute any accrued paid vacation leave, personal leave, or family leave for any part of the 26-week unpaid leave available to care for a service member;
2. when medical treatment is planned and foreseeable, the employee must make reasonable efforts to schedule treatment so as not to unduly disrupt the employer's operations;
3. when both spouses are eligible for leave and work for the same employer, the leave is limited to an aggregate of 26 weeks during any 12-month period;
4. the employer may require a certification issued from the service member's health care provider and the employee must provide this to the employer in a timely manner;
5. intermittent leave or leave on a reduced schedule is allowed and requires, as part of the certification, a statement that the employee's intermittent leave is necessary to care for the service member;
6. an employer may assign an employee on intermittent leave or reduced schedule to a

job of equal pay and benefits that better accommodates the recurring periods of leave;
and

7. the intermittent leave or leave on a reduced schedule certification must include the expected leave duration and the schedule of the intermittent leave or reduced schedule.
State Employee FML Changes. The following provisions are part of the existing state employee FML and the act makes them part of the state employee military caregiver leave. It:

1. requires prior written certification for the leave from the service member's physician, including the probable leave duration, and
2. requires the employee taking leave, before leave begins, to sign a statement of the employee's intent to return to work.

BACKGROUND

Under federal law, if an employee meets the qualifications of both the state and the federal FML acts, the employer is obligated to provide the more generous of the two benefits. The National Defense Authorization Act for FY 2008 (Public Law 110-181) amended the federal FML act to allow eligible employees to take up to 26 weeks of job-protected leave in a single 12-month period to care for a covered service member with a serious injury or ailment. This law covers both the private and public sectors.

Public Act 09-74 (Senate Bill 960)

An Act Concerning the Legislative Commissioners' Recommendations for Technical Revisions to the Insurance Statutes

(Signed by Governor 5/27/2009)

This act makes technical changes in various insurance statutes.

EFFECTIVE DATE: Upon passage

Public Act 09-126 (House Bill 5669)

An Act Concerning Employer Health Insurance Premium Payments for Terminated Employees

(Signed by Governor 6/18/2009)

Under this act, an employer may elect to stop paying group health insurance premiums for an employee and his or her dependents as of 72 hours after the employee quits or is terminated for any reason but a layoff. It outlines requirements and conditions for employers and insurers. The act does not apply if a collective bargaining agreement requires an employer to pay an employee's insurance premiums after his or her termination.

EFFECTIVE DATE: October 1, 2009

REQUIREMENTS AND CONDITIONS

Employer

An employer electing to stop health insurance premium payments due to an employee's termination must, within 72 hours of the employee's termination, notify the (1) employee and (2) affected insurance company, HMO, hospital or medical service corporation, or fraternal benefit society ("insurer"). The act requires an employer to reimburse the affected employee his or her portion, if any, of premiums that the insurance carrier credits or refunds to the employer.

Insurer

An insurer must:

1. when a policy is issued or renewed, give an employer information about the election option, including a notice that it is the employer's responsibility to return to an affected employee his or her portion of credited premiums;
2. credit prepaid premiums to an employer that (a) makes a permissible election and (b) notifies the employee and insurer within 72 hours of the employee's termination; and
3. apply the credit to the employer's next monthly premium bill or, if the policy is not renewed, issue the employer a refund.

Amount of Credit or Refund

The act requires the premium credit or refund to equal the amount of premium previously paid attributable to insuring the employee and his or her dependents for a period after the employee's termination date. But, it specifies that no credit will be made for the first 72 hours following the employee's termination (which is the time period in which the employer must give notice of its election to the employee and insurer).

EMPLOYER DEFINED

Under the act, "employer" means any owner, person, partnership, corporation, limited liability company, or association acting as or on behalf of an employer, or in an employer's interest in relation to employees, including the state and any state political subdivision.

BACKGROUND

Related Labor Law

Under state labor law, an employer that moves out-of-state or closes its business for reasons other than bankruptcy or natural disaster must continue and pay for in full, for each affected employee and his or her dependent, coverage under an existing group health insurance policy for 120 days from the date of the relocation or closing or until the employee becomes eligible for other group coverage, whichever provides the shortest continuation period (CGS § 31-51o). This labor law does not affect an employee's or dependent's right to continue coverage as provided under federal and state insurance law. The coverage continuation under the insurance laws begins when the continuation under the labor law ends.

Related Insurance Law

Federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), and state

law provides certain former employees, retirees, spouses, former spouses, and children the right to temporarily continue being covered under an employer's group health plan after their coverage would otherwise end, so long as the insured pays the required premiums. A person may be required to pay the full premium and administrative costs, up to 102% of the full premium at the group rate. COBRA applies to employer groups with 20 or more employees. Connecticut law applies to all groups regardless of size (CGS § 38a-554(b)).

COBRA establishes the time period for which coverage must continue for a qualified person. A plan may, however, provide longer periods of coverage. COBRA requires coverage to extend for 18 months when a person would otherwise lose coverage because his or her employment ends or work hours are reduced. Other qualifying events, or a second qualifying event during the initial period of coverage, may extend coverage up to 36 months. Longer periods may be available for a disabled person. Under state law, coverage continues for the same duration as under COBRA. In addition, state law permits an employee and his or her covered dependents to continue coverage until midnight of the day preceding the employee's eligibility for Medicare if the employee's reduced hours, leave of absence, or termination of employment results from his or her eligibility for Social Security income.

Connecticut law also requires each group plan to provide for a right to convert to an individual policy when coverage under the group policy would otherwise cease (CGS § 38a-554(d)).

Public Act 09-148 (House Bill 6600)
An Act Concerning the Establishment of the Sustinet Plan
(Vetoed by Governor 7/8/2009)
(Overruled by House and Senate 7/20/2009)

This act establishes a nine-member Sustinet Health Partnership board of directors that must make legislative recommendations, by January 1, 2011, on the details and implementation of the "Sustinet Plan," a self-insured health care delivery plan. The act specifies that these recommendations must address:

1. establishment of a public authority or other entity with the power to contract with insurers and health care providers, develop health care infrastructure ("medical homes"), set reimbursement rates, create advisory committees, and encourage the use of health information technology;
2. provisions for the phased-in offering of the Sustinet Plan to state employees and retirees, HUSKY A and B beneficiaries, people without employer sponsored insurance (ESI), people with unaffordable ESI, small and large employers, and others;

3. guidelines for development of a model benefits package; and
4. public outreach and methods of identifying uninsured citizens.

The board must establish a number of separate committees to address and make recommendations concerning health information technology, medical homes, clinical care and safety guidelines, and preventive care and improved health outcomes. The act also establishes an independent information clearinghouse to provide employers, consumers, and the general public with information about Sustinet and private health care plans.

Finally, the act creates task forces addressing obesity, tobacco usage, and the health care workforce.

EFFECTIVE DATE: July 1, 2009, except that the sections on identifying uninsured adults and children (§§ 14 and 15) and Medicaid and public education outreach (§ 13) take effect July 1, 2011, and the three task forces (§§ 16-18) take effect upon passage.

Public Act 09-158 (Senate Bill 1127)
An Act Concerning Certain State Contracting Nondiscrimination Requirements
(Signed by Governor 6/30/2009)

By law, all state contracts and contracts of political subdivisions, other than municipalities, must contain anti-discrimination provisions that protect people based on race, color, religious creed, age, marital status, national origin, ancestry, sex, mental retardation, physical disability, or sexual orientation. This act defines “marital status” as being single, married under Connecticut law, widowed, separated, or divorced.

The act (1) exempts contracts among public sector parties from the requirement for the anti-discrimination provision, (2) expands the categories of protected people to include those with mental disabilities, and (3) establishes different supportive data that contractors must provide before entering a contract. Under the act, “mental disability” means one or more mental disorders, as defined in the latest edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. The act defines “mental impairment,” as that term is used in the small business and minority enterprise program in the same way.

This means that a small contractor with at least one of these disorders that substantially limits one or more of his or her major life activities meets the definition of a minority enterprise. By law, state and quasi-public agencies and political subdivisions, other than municipalities, must set aside a percentage of the contracts they award for construction, goods, and services each year for small contractors and minority business enterprises.

EFFECTIVE DATE: Upon passage

ANTI-DISCRIMINATION PROVISION IN CONTRACTS

Contracts Requiring the Provision

Under prior law, all state contracts and contracts of political subdivisions, other than municipalities, had to contain anti-discrimination provisions. The act limits this requirement by exempting contracts between governmental or quasi-governmental entities. Specifically, the requirement does not apply to contracts in which the contractor is either (1) a political subdivision, including a municipality; (2) a quasi-public agency; (3) another state; (4) the federal government; (5) a foreign government; or (6) an agency of any of the above.

Categories of People Protected by the Provisions

The act requires that these contracts require contractors to agree not to (1) discriminate or permit anyone to discriminate against anyone with mental disabilities and (2) treat their employees differently because of a mental disability unless the disability prevents the person from performing a job.

Supportive Data

Under prior law, contractors had to provide their company's anti-discrimination policy adopted by a resolution of its governing body before entering a contract with the state or a political subdivision. The act makes this requirement one option available to contractors with contracts valued at \$50,000 or more for any year of the contract. The other options are to (1) provide a policy adopted by a prior resolution that a duly authorized corporate officer certifies is still in effect and that the head of the contracting agency certifies complies with the law's antidiscrimination agreement and warranty or (2) submit an affidavit signed under penalty of false statement by a corporate officer duly authorized to adopt company policy that certifies that the policy complies with the law's antidiscrimination agreement and warranty and is effective on the date the affidavit is signed. In establishing the \$50,000 threshold, the act eliminates a requirement for contractors with a contract below this threshold to provide their company's antidiscrimination policy. It instead requires them to give the state or the political subdivision, as applicable, a written representation that complies with the nondiscrimination agreement and warranty.

BACKGROUND

Diagnostic and Statistical Manual of Mental Disorders

The manual (known as the "DSM-IV") lists approximately 400 disorders of varying degrees of severity. It is the standard classification of mental disorders used by mental health professionals in the United States. It was substantially revised in 1994.

Public Act 09-174 (House Bill 6231)

An Act Concerning the Use of a Certificate, Professional Designation or Advertising in Advising Senior Citizens

(Signed by Governor 7/2/2009)

This act prohibits anyone directly or indirectly involved in securities sales from falsely expressing or implying that they have special training, education, or experience in providing financial advice or services to seniors. The act exempts from this prohibition a person who meets certain education requirements and allows the banking commissioner to adopt implementing regulations. A person who willfully violates this prohibition is subject to a fine of up to \$2,000, two years imprisonment, or both.

The act also requires the insurance commissioner to adopt regulations pertaining to the sale of life insurance or annuities to seniors and requires him to take certain enforcement actions against anyone who violates these regulations.

EFFECTIVE DATE: July 1, 2009

EDUCATION REQUIREMENTS

Under the act, a person cannot sell, purchase, or offer securities using a senior-specific certificate, title, or professional designation unless it was obtained by completing (1) an academic degree in a related field from an accredited higher education institution or (2) a course of study in a related field provided by an organization accredited by:

1. the American National Standards Institute,
2. the National Commission for Certifying Agencies,
3. an organization recognized as an accrediting agency by the U. S. Department of Education pursuant to the 1965 Higher Education Act, or
4. any other organization approved by the banking commissioner.

The act prohibits a person who meets these requirements from using the certificate, title, or professional designation in a false or deceptive manner. It also requires the banking commissioner to determine whether a person's academic degree is in a related field.

INSURANCE REGULATIONS

The act requires the insurance commissioner to adopt regulations to (1) prevent misleading or fraudulent marketing practices regarding life insurance and annuities sold to seniors and (2) set standards for the use of senior-specific certification and professional designations used in life insurance and annuities sales.

Under the act, a person who violates these regulations is subject to license suspension or revocation, a fine of up to \$5,000, or both.

Securities Sales and Unethical Practices

The law prohibits anyone from directly or indirectly engaging in any dishonest or unethical practice in connection with a security offer, sale, or purchase. It prohibits anyone from (1) employing any device, scheme, or artifice to defraud; (2) making any untrue statement of a material fact or omitting a material fact needed to make the

statements not misleading; or (3) engaging in any act, practice, or course of business that operates or would operate as a fraud or deceit upon anyone.

Public Act 09-204 (Senate Bill 47)

An Act Concerning Contracts Between Health Care Providers and Contracting Health Organizations

(Signed 7/8/2009)

This act expands the (1) fee information a managed care organization or preferred provider network (i.e., contracting health organization) must give to health care providers with whom it contracts and (2) list of providers to whom the requirement and related provisions apply. It prohibits contracting health organizations from making material changes to a provider's fee schedule except as the act specifies. It also requires a contracting health organization to give each contracted provider Internet, electronic, or digital access to policies and procedures regarding providers' (1) payments, (2) duties and requirements under the contract, and (3) inquiries and appeals, including (a) contact information for the office responsible for responding to them and (b) a description of appeal rights applicable to providers, enrollees, and enrollees' dependents.

The act prohibits a contracting health organization, more than 18 months after receiving a clean (i.e., complete) claim, from canceling, denying, or demanding the return of full or partial payment it made in error for an authorized covered service except under specified circumstances and subject to certain procedures.

EFFECTIVE DATE: January 1, 2010, except for the provisions relating to material changes to fee schedules and cancellation of authorized covered services, which are effective July 1, 2010.

ACCESS TO CODES AND FEES

Prior law required contracting health organizations to allow a contracted physician, physician group, or physician organization to confidentially view, in a digital format, the fees payable for the 50 current procedural terminology (CPT) codes most commonly performed by the physician, group, or organization. The law applied with respect to physicians, surgeons, chiropractors, podiatrists, psychologists, and optometrists. The act instead requires the organization to establish and implement a procedure to provide each contracted provider Internet, electronic, or digital access to the organization's fees for the CPT and the Health Care Procedure Coding System (HCPCS) codes (1) applicable to the provider's specialty and (2) that the provider requests for other services for which he or she actually bills or intends to bill the organization, provided the codes are within the provider's specialty or subspecialty. The act defines "provider" as a physician, surgeon, chiropractor, podiatrist, psychologist, optometrist, naturopath, or advanced practice registered nurse licensed in Connecticut, or a group or organization of such people, who has entered into or renews a participating provider contract with a

contracting health organization to render services to the organization's enrollees and enrollees' dependents.

By law, (1) the right to access fees applies only to a provider whose services are reimbursed using CPT codes and (2) fee information is proprietary and confidential. The organization may penalize the unauthorized distribution of the information, including terminating the provider's contract.

CHANGES TO FEE SCHEDULES

The act prohibits contracting health organizations from making material changes to a provider's fee schedule except as specified. A contracting health care organization may make changes once a year if it gives providers at least 90 days' advance notice by mail, e-mail, or fax. Upon receipt of the notice, a provider may terminate its contract by giving the organization at least 60 days' advance written notice.

The act also allows an organization to make changes at any time if it gives providers at least 30 days' advance notice by mail, e-mail, or fax if the changes are:

1. to comply with a federal or state requirement, but if the requirement takes effect in fewer than 30 days, the organization must give providers as much notice as possible;
2. to comply with changes to the medical data code sets in federal regulations (45 CFR 162. 1002);
3. to comply with changes to national best practice protocols made by the National Quality Forum or other national accrediting or standard-setting organization based on peer-reviewed medical literature generally recognized by the relevant medical community or the results of clinical trials generally recognized and accepted by the relevant medical community;
4. consistent with changes in Medicare billing or medical management practices, as long as the changes are made to relevant provider contracts and relate to the same specialty or payment methodology;
5. because the federal Food and Drug Administration (FDA) or peer-reviewed medical literature generally recognized by the relevant medical community identifies a drug, treatment, procedure, or device as no longer safe and effective;
6. to address payment or reimbursement for a new drug, treatment, procedure, or device that becomes available and is determined to be safe and effective by the FDA or by peer-reviewed medical literature generally recognized by the relevant medical community; or
7. mutually agreed to by the organization and the provider.

PAYMENT CANCELLATION, DENIAL, OR RETURN

The act prohibits a contracting health organization, more than 18 months after receiving a clean (i. e. , complete) claim, from canceling, denying, or demanding the return of full or partial payment for an authorized covered service due to administrative or eligibility error, unless the:

1. organization (a) has a documented basis to believe that the provider fraudulently submitted the claim, (b) already paid the provider for the claim, or (c) paid a claim that should have been or was paid by a federal or state program; or

2. provider (a) did not bill the claim appropriately based on documentation or evidence of what medical service was actually provided or (b) received payment from a different insurer, payor, or administrator through coordination of benefits, subrogation, or coverage under an automobile insurance or workers' compensation policy.

The act gives a provider that receives a payment from another source one year after the date of the payment cancellation, denial, or return to resubmit an adjusted claim with the organization on a secondary payor basis, regardless of the organization's timely filing requirements.

Advance Notice Required

The act requires an organization to give a provider at least 30 days' advance notice of a payment cancellation, denial, or return demand by mail, e-mail, or fax. The organization must include in a notice demanding a return of payment the (1) amount it wants returned, (2) claim to which it relates, and (3) basis for it.

Appeal

The act allows a provider to appeal, in accordance with the organization's procedures, a payment cancellation, denial, or return demand within 30 days after receiving notice of it. It requires a payment return demand to be stayed (i. e. , postponed) during the appeal.

Adjusted Claim

If there is no appeal or an appeal is denied, the act allows a provider to resubmit an adjusted claim, if applicable, to the organization within 30 days after receiving notice of (1) a payment cancellation or denial or (2) an appeal denial. A claim may not be resubmitted if the organization demanded a return of payment.

Other Appropriate Insurance Coverage

The act gives a provider one year after the date of the written notice of a payment cancellation, denial, or return demand to (1) identify any other appropriate insurance coverage applicable on the date of service and (2) file a claim with the insurer, HMO, or other issuing entity, regardless of its timely filing requirements.

BACKGROUND

HMO Provider Contracts and Billing Enrollees

By law, every contract between an HMO and a participating provider of health care services must be in writing and contain specified provisions or variations the insurance commissioner approves. If the participating provider contract is not in writing or does not have the specified provisions, the law prohibits the provider from collecting or attempting to collect from the subscriber or enrollee any amount for which the HMO is responsible (CGS § 38a-193(c)). When an HMO has primary payment responsibility, the law makes it an unfair trade practice for a provider to (1) request payment from an enrollee, other than a copayment or deductible, for covered medical services or (2) report to a credit reporting agency an enrollee's failure to pay a bill for medical services (CGS § 20-7f).

Prompt Claim Payments

By law, an insurer or other entity must pay a clean claim within 45 days of receiving it (CGS § 38a-816(15)). If a claim contains a deficiency, the insurer must send written notice to the claimant or health care provider, as the case may be, of all alleged

deficiencies within 30 days of receiving the claim. The insurer must process the claim within 30 days of receiving the corrected claim and add 15% interest if payment is late.

Public Act 09-210 (Senate Bill 954)

An Act Concerning Personal Service Agreements, Purchase of Service Contracts and Nonemergency Medical Transportation Services

(Signed by Governor 7/8/2009)

The law establishes two types of contracts that state agencies execute when procuring services from private providers—personal service agreements (PSA) and purchase of services (POS) contracts. PSAs are written agreements defining the services or end product to be delivered by a contractor to a state agency. A POS is a contract between a state agency and a private provider organization or municipality for the purchase of ongoing direct health and human services for agency clients. This act:

1. changes how the Office of Policy and Management (OPM) reports to the legislature annually on PSA activities, and eliminates a requirement that OPM report on POS activities;
2. eliminates (a) the requirement that state agencies submit semi-annual reports on their PSA activities and (b) other reporting requirements;
3. prohibits state agencies from hiring certain health or human service providers without first executing POS contracts; and
4. clarifies the POS definition.

The act also deletes an obsolete reference to purchase orders and makes technical and conforming changes.

Additionally, the act requires any contractor (broker) (1) to which DSS awards a contract to coordinate nonemergency transportation (NEMT) to Medicaid recipients and (2) that also coordinates transportation for individuals not receiving Medicaid to disclose to any transportation provider with which it contracts the source of payment when the transportation service is requested. (If the Medicaid recipient requests the transport from the broker, the broker would not be able to contact the provider at the same time.)

And the act requires all NEMT brokers to make prior authorization (PA) decisions for nonemergency hospital discharge ambulance trips no later than three business days after the hospital or ambulance company submits the PA request. If the broker fails to communicate a decision by the deadline, the request is deemed approved.

EFFECTIVE DATE: Upon passage, except the NEMT provisions are effective on July 1, 2009 and the provision requiring the annual reports on PSAs is effective October 1, 2009.

PERSONAL SERVICE AGREEMENTS (PSA) AND PURCHASE OF SERVICE (POS) CONTRACTS

Beginning October 1, 2009, the act requires the OPM secretary annually to submit a

report to the General Assembly on PSAs executed during the preceding fiscal year. This information includes the name of the personal service contractor, a description of services provided, the term and cost of the agreement, selection methods, and amounts paid for each contract. The act eliminates a requirement that OPM submit a summary report on PSA activity annually.

Previously, the Department of Transportation (DOT), every six months, had to report to OPM on agreements it executed with (1) persons or entities performing consultant services or (2) federal or state agencies. The act instead requires OPM to report separately to the General Assembly on agreements for these specific types of contracts, not just DOT ones, executed during the preceding fiscal year, as well as those for contractual services as defined in state law (see BACKGROUND).

By law, personal service contractors are people or entities that state agencies hire to provide services to the agency. They do not include those performing contractual or consultant services (CGS § 4-212).

Finally, the act eliminates a requirement that the OPM secretary report every two years on the POS system.

Elimination of Agency Responsibilities

The act eliminates two separate requirements that every six months each state agency submit reports to the OPM secretary on PSAs executed during the previous six months. The first one required a report for PSAs costing no more than \$20,000. The second one required a reporting of PSAs executed with a person, firm, or corporation providing “contractual services,” regardless of the PSA cost, as well as those between agencies and consultants and federal or state agencies. By definition, a PSA cannot cover these types of services so it is not clear how this was interpreted under prior law.

The act also eliminates a requirement that each agency with proposed PSAs costing between \$20,001 and \$50,000 submit information about the PSAs to OPM at the same time it submits the information to the commissioner of administrative services or the attorney general.

Purchase of Service (POS) Contracts

The act codifies prior practice by prohibiting state agencies from hiring a private provider organization or municipality to provide direct health or human services to the agency's clients without executing a POS contract with them.

The act explicitly subjects POS contracts to the same competitive procurement requirements as the law requires for PSAs. The law already authorizes the OPM secretary to waive these requirements for POS contracts.

The act specifies that POS contracts are generally not for administrative or clerical services, material goods, training, or consulting services and do not include a contract with an individual.

The act also defines terms already in the POS law. For example, it defines a “private provider organization” as a nonstate entity that is either a for- or nonprofit corporation or partnership that receives funds from the state, and may receive federal or other funds, to provide direct health and human services to agency clients.

BACKGROUND

Contractual and Consulting Services

The law governing general state purchases defines “contractual services” as any and all (1) laundry and cleaning, pest control, janitorial, or security services; (2) rental or repair or maintenance of equipment, machinery, and other state-owned personal property; (3) advertising, photostating, and mimeographing; and (4) other service arrangements where the services are provided by someone other than a state employee.

“Consultants” are defined in the state law governing the construction and alteration of state buildings as (1) architects, professional engineers, landscape architects, land surveyors, accountants, interior designers, environmental professionals, or construction administrators registered or licensed to practice their profession or (2) planners or financial specialists.

Core-CT and PSA and POS Reports

CORE-CT, the state's central financial and administrative computer system, encompasses central and agency accounting functions for executive branch agencies. Since 2005, agencies have been required to enter their contracting data into CORE-CT, and OPM has the ability to generate reports about agencies' PSA and POS activities. OPM requires agencies to enter all contract data with CORE-CT and can access this data to get the reports that the law requires the agencies to provide. OPM's annual report on PSAs includes POS contract activity.

No Legal Distinction Between PSA and POS

In 2005, the attorney general issued a formal opinion (No. 031) that there is no legal distinction between a PSA and POS contract, and that both are subject to competitive procurements.

Medicaid Nonemergency Transportation

DSS presently contracts with three transportation brokers that coordinate nonemergency transportation for Medicaid recipients. State regulations require prior authorization (PA) for most nonemergency ambulance trips, and the brokers must obtain this from DSS before they can authorize them. The contracts do not require the brokers to obtain PA within a specific time, including after hours and weekends, but at least two have back-up systems to receive and respond to PA requests.

Public Act 09-225 (House Bill 6672)

An Act Concerning the 2008 Amendments to the Uniform Common Interest Ownership Act

(Signed by Governor 7/8/2009)

This law makes numerous unrelated changes and additions to the Connecticut Common Interest Ownership Act (CIOA). Only insurance related provisions are included in the summary below.

The law includes several changes regarding insurance. It requires the association to carry fidelity insurance. It specifies that the association may choose to proceed directly against the unit owner and not file an insurance claim in cases of willful misconduct or gross negligence by the unit owner or the owner's guest or invitee.

EFFECTIVE DATE: October 1, 2009

§ 26 — INSURANCE

The bill requires the association to carry fidelity insurance. This type of insurance protects the association from loss of money, securities, or inventories resulting from crime. Common fidelity insurance claims allege employee dishonesty, embezzlement, forgery, robbery, safe burglary, computer fraud, wire transfer fraud, counterfeiting, and other similar criminal acts.

Current law requires the association to ensure units, as well as the common elements, only in the case of so-called “stacked” units in a high-rise building. The bill requires unit insurance coverage also in the case of common interest communities with units that have party walls, to the extent reasonably available. But it need not include improvements and betterments installed by unit owners.

The bill specifies that the insurance the association must maintain may be subject to reasonable deductibles.

Public Act 09-237 (Senate Bill 457) **An Act Concerning Motor Vehicle Repairs** *(Signed by Governor 7/8/2009)*

This act prohibits an auto insurer, and its agents and adjusters, from (1) requiring an insured to use a specific motor vehicle repair shop to perform auto repairs or (2) stating that repair work will be delayed or not guaranteed if the insured has repairs performed at a repair shop that does not participate in the insurer's vehicle repair program. Prior law permitted an insurer to require a specific facility if the insured agreed to it in writing. The act revises the written acknowledgement that a motor vehicle repair shop must obtain from a customer. Prior law required a shop participating in an insurer's repair program to have a customer's acknowledgement state: “I am aware of my right to choose the licensed repair shop where the damage to the motor vehicle will be repaired.” The act instead requires all motor vehicle repair shops to obtain a customer acknowledgement that states: “I am aware of my right to choose the licensed repair shop where the motor vehicle will be repaired.” The acknowledgement is in addition to, or may be part of, the customer's written authorization to perform work, which a repair shop must obtain by law before performing any repair work. As under prior law, the acknowledgement may be sent by e-mail or fax.

By law, a violation of any law or regulation that applies to its business as motor vehicle dealer or repairer licensee may result in a license suspension or revocation, a civil penalty of up to \$1,000 for each violation, or both (CGS § 14-64). Any person or corporation that violates any provision of the state insurance code for which no other penalty applies is subject to a fine of up to \$15,000 (CGS § 38a-2).

EFFECTIVE DATE: October 1, 2009

BACKGROUND

Vehicle Repair Program

Some automobile insurers enter into contracts with specific repair shops that agree to provide services to customers at a discounted price. A person may choose any shop for repairs, but the insurer might only guarantee repairs performed at a shop that participates in its repair program.

Licensed Repair Shop

By law, no one may operate a motor vehicle repair shop without a Department of Motor Vehicle-issued new car dealer's, used car dealer's, repairer's, or limited repairer's license. A "motor vehicle repair shop" means a new car dealer, a used car dealer, a repairer, or a limited repairer.

"Repairer" includes any person, firm, or corporation qualified to conduct such business, having a suitable facility and adequate equipment, engaged in repairing, overhauling, adjusting, assembling, or disassembling any motor vehicle. It excludes a person engaged in tire repairs, upholstery, glazing, general blacksmithing, welding, and machine work on motor vehicle parts when a licensed repairer disassembles and reassembles the parts.

"Limited repairer" includes any qualified person, having a suitable place of business and adequate equipment, engaged in the business of minor repairs, including cooling, electrical, fuel, and exhaust system repairs and replacement; brake adjustments, relining, and repairs; wheel alignment and balancing; and shock absorber repairs and replacement. It excludes lubricating motor vehicles; adding or changing oil or other motor vehicle fluids; changing tires and tubes, including the balancing of wheels; or installing batteries or light bulbs, windshield wiper blades, or drive belts.

Public Act 09-240 (Senate Bill 894)

An Act Requiring Disclosure of Automobile Liability Insurance Policy Limits Prior to the Filing of a Claim

(Signed by Governor 7/8/2009)

This act requires an automobile liability insurer to disclose the limits applicable under a policy it issued within 30 days after receiving a written request for disclosure. The request must be made by, or on behalf of, a person alleging bodily injury or death resulting from a motor vehicle collision involving a person the insurer's private passenger automobile policy covers. The disclosure must be in writing and indicate all coverage the

insurer provides to the insured, including any applicable umbrella or excess liability insurance.

The act requires that the request include a letter from an attorney licensed to practice in Connecticut or an affidavit from the person alleging to have suffered injury in the accident that includes certain information. The request must be sent by certified mail to the insurance adjuster or company at its last known principal place of business.

EFFECTIVE DATE: October 1, 2009, and applicable to claims arising on or after that date.

ATTORNEY LETTER

The attorney's letter or the person's affidavit must include:

1. his or her juris number (if an attorney),
2. the type of claim alleged against the insured,
3. the date and approximate time the alleged incident occurred,
4. a description of the injuries the insured is alleged to have caused;
5. a copy of the person's medical bills and treatment records for the injuries; and
6. a copy of the accident report of the collision that allegedly caused the person's injury or death, if available.

Other Acts of Interest

Public Act 09-23 (House Bill 6327)

An Act Concerning Surety Bonds for Debt Adjusters

(Signed by Governor 5/8/2009)

This act changes the method for calculating the required surety bond that debt adjusters must file with the banking commissioner. It also sets the bond for a debt adjustor applicant who acquires a predecessor's business. The act (1) allows the banking commissioner to change the bond amount based on certain conditions and (2) requires applicants who cannot meet the bond requirements to deposit a certain amount in a bank, instead of obtaining an insurance policy as is the option under current law. It also makes conforming changes.

EFFECTIVE DATE: July 1, 2009

Public Act 09-104 (Senate Bill 778)

An Act Concerning Evidence of Workers' Compensation Insurance for Contractors on Public Works Projects

(Signed by Governor 6/2/2009)

The law requires applicants for a license or permit necessary to operate a business to present "sufficient evidence" of compliance with the workers' compensation insurance coverage requirements. This act allows applicants for licenses and permits issued by the Department of Consumer Protection to meet the sufficient evidence requirement by providing the name of the applicant's insurer, the policy number, and the effective coverage dates, certified as truthful and accurate, as an alternative to presenting a hard copy of the insurance certificate. Prior law required applicants to present a hard copy of a certificate of self-insurance issued by a workers' compensation commissioner, a certificate of compliance issued by the insurance commissioner, or a certificate of insurance issued by a stock or mutual insurance company.

EFFECTIVE DATE: Upon passage

Public Act 09-122 (House Bill 6501)

An Act Eliminating Surety Bond Requirements for Residential Underground Heating Oil Tank Removal or Replacement Contractors

(Signed by Governor 6/9/2009)

This act eliminates the requirement that a contractor who intends to remove or replace

residential underground heating oil tanks provide evidence of a \$250,000 surety bond to the Department of Consumer Protection (DCP) when applying for a home improvement contractor registration certificate. It does not change the requirements that the applicant show that he has (1) completed the hazardous material training program approved by the Department of Environmental Protection (DEP) and (2) liability insurance coverage of \$1 million. For contractors who wish to register for payment from DEP's residential underground heating oil storage tank clean-up subaccount, it eliminates a surety bond as a way to prove financial responsibility and raises the minimum amount of liability insurance coverage or liquid company assets that contractors must have from \$250,000 to \$1 million. It does not change the requirements that contractors provide DEP with evidence of training and experience to register.

EFFECTIVE DATE: Upon passage

Public Act 09-134 (House Bill 6448)

An Act Concerning Disclosure of Insurance Requirements in Equipment Leases

(Signed by Governor 6/18/2009)

This act (1) expands disclosure requirements under the Uniform Consumer Leases Act about insurance a lease agreement may require and (2) changes the name of the act to the Consumer Leases Act. The act also applies its insurance disclosure requirements to a lease that is subject to the Uniform Commercial Code (UCC). The UCC allows the parties to a lease to agree upon (1) who must obtain and pay for insurance and (2) the insurance beneficiary.

EFFECTIVE DATE: October 1, 2009 and, other than the name change, applicable to consumer leases entered, renewed, modified, or extended on or after October 1, 2009.

DISCLOSURE REQUIRED

By law, a lease agreement may require a lessee to maintain (1) casualty insurance on the leased goods, (2) liability insurance against personal injury or property damage caused to others, or (3) both. Under prior law, if a leaseholder required a lessee to maintain insurance, it had to disclose that the lessee could choose the insurer, subject to the leaseholder's right to reject the insurer for reasonable cause. But this provision did not apply if the insurance was included in the lease for no additional cost to the lessee. The act instead requires a leaseholder to make this disclosure if (1) the insurance required is not included in the lease or (2) there is an additional charge for obtaining the insurance through the leaseholder.

The act requires the leaseholder also to disclose (1) whether the insurance required is included in the lease for no additional charge and (2) that insurance policies the leaseholder offers may duplicate coverage the lessee has under his or her personal insurance policies.

By law, the disclosures must be made in a record (information inscribed on a tangible medium or stored in an electronic or other media that is retrievable in a perceivable form). If casualty insurance is neither required nor provided, the law requires the lease to state this or be accompanied by a record that substantially states, "No insurance coverage for physical damage to the leased goods, or loss of the leased goods, is provided under this lease." The act requires this statement and the required disclosures to be conspicuous. When a lease obligates a lessee to pay for insurance the leaseholder provides, the law requires the leaseholder to either give a copy of the policy or insurance certificate to the lessee or arrange for it to be provided.

Public Act 09-206 (Senate Bill 1048)
An Act Concerning Health Care Cost Control Initiatives
(Signed by Governor 7/8/2009)

NOTE: See Public Act 09-232, Section 28, that deletes the requirement that the Insurance Commissioner assist in developing a plan concerning the bulk purchasing of pharmaceuticals.)

This act requires the Social Services (DSS) and Administrative Services (DAS) commissioners and the comptroller, in consultation with the Public Health (DPH) and Insurance commissioners, to develop a plan concerning the bulk purchasing of pharmaceuticals. Specifically, the plan must implement and maintain a prescription drug purchasing program and procedures to aggregate or negotiate pharmaceutical purchases for HUSKY Part B, State Administered General Assistance, Charter Oak Plan and ConnPACE recipients, Department of Correction inmates, and people eligible for insurance under the state employees and municipal employee health insurance plans. (PA 09-232, sec. 28, eliminates the insurance commissioner's consultative role in developing the plan.)

The plan must include the state joining an existing multistate Medicaid pharmaceutical purchasing pool. It must determine whether it is feasible to subject some or all of the programs listed above to the preferred drug lists adopted by DSS for its various programs.

The act requires DSS to submit the plan to the Public Health and Human Services committees by December 31, 2009. The plan must include (1) an implementation timetable, (2) anticipated costs or savings, (3) a timetable for achieving any savings, and (4) legislative recommendations.

The act also prohibits (1) hospitals and outpatient surgical facilities from seeking payment for costs associated with certain hospital-acquired conditions and (2) specified

health care practitioners from charging for certain imaging services.

EFFECTIVE DATE: July 1, 2009 for the bulk purchasing provisions; October 1, 2009 for the imaging service provision; and January 1, 2010 for the provision on hospitals and outpatient surgical facility billing for hospital-acquired conditions.

Public Act 09-222 (House Bill 6642)

An Act Concerning Solicitation of Clients, Patients or Customers

(Signed by Governor 7/8/2009)

This act makes it illegal for anyone to act as a “runner” by knowingly, and for financial gain, getting or attempting to get a patient, client, or customer for “providers.” It specifies that people can engage in certain activities without being considered “runners.” Providers are attorneys, health care professionals, legal or health care services business owners or operators, people pretending that they or their business or practice can provide such services, or an employee of or anyone acting on behalf of any of these people, who:

1. seek to obtain benefits under an insurance contract;
2. assert a claim against an insured or an insurance carrier for providing services to the client, patient, or customer; or
3. obtain benefits under or assert a claim against a state or federal health care benefits program or prescription drug assistance program.

The act also makes it a crime to solicit, direct, hire, or employ someone as a runner. The penalty for acting as, or hiring, a runner is imprisonment for up to one year, a fine of up to \$5,000, or both. The criminal penalties do not apply to the referral of individuals between (1) attorneys, (2) health care professionals, or (3) attorneys and health care professionals.

The act specifies that its prohibitions and penalties are in addition to, and cannot be interpreted to limit or restrict, the laws that (1) prohibit soliciting people to file lawsuits for damages, or soliciting cases for attorneys, or (2) limit communications by attorneys to prospective clients (see BACKGROUND).

EFFECTIVE DATE: October 1, 2009

RUNNER

The act specifies that a “runner” does not include an individual who:

1. procures or attempts to procure clients, patients, or customers for a provider through public media;
2. refers prospective clients, patients, or customers to a provider as otherwise authorized by law;
3. facilitates, presents, or speaks at a meeting, program, or seminar that is open to the public and at which information about a provider's services are discussed; or
4. is a bona fide employee of a provider who responds to an inquiry or request for information initiated by a prospective client, patient, or customer.

Under the act, “public media” means telephone directories, professional directories, newspapers and other periodicals, radio and television, billboards, mail, or electronically transmitted written communications that do not involve in-person contact with a specific prospective client, patient, or customer.

PROVIDER

Under the act a “provider” is: an attorney; a health care professional; a person who owns or operates a business or entity that provides legal or health care services; a person who, by his or her representations, creates a reasonable belief that he or she or his or her practice, business, or entity can provide legal or health care services; or a person employed by or acting on behalf of any of these persons.

A health care professional includes any person licensed or who holds a permit for or as: Medicine and surgery; chiropractic; natureopathy; podiatry; athletic training; physical therapists; occupational therapists; substance abuse counselors; radiographer and radiologic technologist; midwifery; nursing; dentistry; dental hygienists; optometry; optician; respiratory care practitioner; psychologist; marital and family therapist; clinical social worker; professional counselor; veterinary medicine; massage therapist; dietitian and nutritionist; acupuncturist; paramedic; embalmer and funeral director; hearing instrument specialist, or speech and language pathologist and audiology.

BACKGROUND

Related Law-Soliciting Persons to Sue for Damages

The law prohibits individuals not licensed as attorneys from soliciting, advising, requesting, or inducing another person to cause a lawsuit for damages to be instituted, if (1) he or she may, by agreement or otherwise, directly or indirectly, receive compensation from the person filing suit or his or her attorney or (2) the attorney's compensation for instituting or prosecuting the action depends upon the amount of the recovery. Violators are subject to a fine of up to \$100, imprisonment up to six months, or both (CGS § 51-86).

Related Law-Solicitation of Cases for Attorneys

The law makes it a crime for anyone to pay, remunerate, or reward:

1. any other person with something of value to solicit or obtain a cause of action or client for an attorney;
2. any other person with something of value for soliciting or bringing a cause of action or a client to an attorney;
3. a police officer, court officer, correctional institution officer or employee; physician or hospital employees; automobile repairman, tower or wreckers; funeral director; or any other person who induces any person to seek the services of an attorney; or
4. any other person as an inducement to bring a cause of action to, or to come to, an attorney or to seek his professional services.

The law also makes it a crime to employ an agent, runner, or other person to solicit or obtain a cause of action or a client for an attorney. Violators are subject to a fine of up to \$10,000 or imprisonment of up to three years or both. The law does not prohibit an

attorney from engaging others for professional assistance or referring a case to another attorney (CGS § 51-87(a)).

The law also makes it a crime for anyone to knowingly receive or accept any payment, remuneration, or reward for (1) referring or bringing a cause of action or prospective client to an attorney or (2) inducing or influencing any other person to seek the professional advice or services of an attorney. Violators are subject to a fine of up to \$1,000, imprisonment for up to three years, or both. The law does not apply to an attorney referring causes of action or clients or other persons to another attorney (CGS § 51-87(b)).

Related Law-Limitations on Written Communications to Prospective Clients.

An attorney may not send, or knowingly permit to be sent, on behalf of his or her firm or other attorneys affiliated with his or her firm a written communication to a prospective client to obtain professional employment if:

1. the written communication concerns an action for personal injury or wrongful death or otherwise relates to an accident or disaster involving the person to whom the communication is addressed or a relative of that person, unless the accident or disaster occurred more than 40 days before the communication is mailed;
2. the written communication concerns a specific matter and the attorney knows or reasonably should know that the person to whom the communication is directed is represented by an attorney in the matter;
3. the attorney knows that the person does not want to receive such communications from him or her;
4. the communication involves coercion, duress, fraud, overreaching, harassment, intimidation, or undue influence;
5. the communication contains a false, fraudulent, misleading, deceptive, or unfair statement or claim; or
6. the attorney knows or reasonably should know that the physical, emotional, or mental state of the person makes it unlikely that the person would exercise reasonable judgment in employing an attorney.

The law also contains certain requirements concerning written communications to prospective clients known to be in need of legal services in a particular matter for the purpose of obtaining professional employment (CGS § 51-87a).

Public Act 09-232 (House Bill 6678)

**An Act Concerning Revisions to Department of Public Health Licensing Statutes
(Signed by Governor 7/8/2009)**

NOTE: See Public Act 09-206, that required the Insurance Commissioner to assist in developing a plan concerning the bulk purchasing of pharmaceuticals. Section 28 of this Public Act deletes the requirement that the Insurance Commissioner assist in the development of that plan.

This law makes a number of substantive and minor changes to laws governing Department of Public Health (DPH) programs and health professional licensing.
EFFECTIVE DATE: October 1, 2009