



# **CONNECTICUT INSURANCE DEPARTMENT**

## **LEGISLATIVE SUMMARY 2010**

# Connecticut Insurance Department 2010 Legislative Summary

## Forward

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

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**Acts of Direct Interest to the Insurance Department**  
**Life and Health**

**Public Act 10-1 (House Bill 5015)**

**An Act Concerning State Continuation of Group Health Insurance Coverage, Appointments to Legislative Commissions, Property Tax Exemptions and the Effective Dates of Bonds for Road Surfacing**

*(Signed by Governor 2/9/2010)*

*The following summary references only those provisions of Public Act 10-1 related to State Continuation of Group Health Insurance Coverage.*

Section 1 – CONTINUATION OF HEALTH INSURANCE COVERAGE

The act specifies that the federal American Recovery and Reinvestment Act of 2009 (ARRA) (P. L. 111-5), as amended, governs premium assistance and notice requirements related to continuation of health insurance coverage for “assistance-eligible individuals” (i.e., certain laid-off workers). Thus, insurers, HMOs, and administrators of group health insurance policies subject to the state continuation law (“mini-COBRA”), including employers with fewer than 20 employees, must comply with ARRA's subsidy and notice requirements for coverage available through the Consolidated Omnibus Budget Reconciliation Act (COBRA). The act specifies that it does not affect a person's right to continue coverage as required by state law.

The act replaces related provisions included in PA 09-3 that have expired and is in response to federal action to extend the eligibility period and the duration of the COBRA subsidy available under ARRA. ARRA provides a 65% subsidy to assistance-eligible individuals to help them continue their previous employer-sponsored coverage through COBRA. Congress extended this subsidy through several subsequent acts.

Under the original ARRA law, only workers laid-off from September 1, 2008 to December 31, 2009 qualified for the subsidy. Under the extensions, people who are laid off from September 1, 2008 to May 31, 2010 can qualify. Additionally, a person's subsidy can last for up to 15, instead of up to nine, months. The extension requires group health plan administrators to send specified notices to affected individuals.

Under the act, if a person who is eligible for the ARRA subsidy elects to continue coverage under state law, then the insurer, when determining whether the person had maintained continuous coverage for purposes of applying state law regarding preexisting conditions, must disregard the period of time from when the person first became eligible

for continued coverage and the date (on February 17, 2009 or later) when the person's continued coverage began when determining if coverage was continuous (see BACKGROUND).

**EFFECTIVE DATE: Upon passage**

## BACKGROUND

### *COBRA and Mini-COBRA*

COBRA gives certain former employees, retirees, spouses, and dependent children the right to temporarily continue health coverage under the employer's group health plan after their coverage would otherwise end, so long as the insured pays the required premiums. It applies to employers with 20 or more employees. Connecticut has a "mini-COBRA" law that applies to employers regardless of size, including those with fewer than 20 employees (CGS §§ 38a-538, 546, and 554).

COBRA establishes the minimum time period for which coverage must continue for a qualified person. A plan may, however, provide longer periods of coverage. COBRA requires coverage 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.

In the absence of the temporary federal subsidy, a person may be required to pay the full premium and administrative costs for the coverage, up to 102% of the full premium at the group rate.

### *Required Coverage for Preexisting Conditions*

If a person's prior plan covered his or her preexisting condition, the succeeding plan must also cover the condition, provided (1) the prior coverage was continuous to a date not less than 120 days, or if the previous coverage was terminated due to an involuntary loss of employment 150 days, before the new plan's effective date and (2) the person applies for the new coverage within 30 days of his initial eligibility (CGS § 38a-476(c)).

## **Public Act 10-4 (House Bill 5002)**

### **An Act Concerning Premium Quotes and Information for Small Employer Health Insurance Coverage**

*(Signed by Governor 5/5/2010)*

This act establishes the Connecticut Clearinghouse, from which individuals and small employers (i.e., employers with 50 and fewer employees) may obtain information about health insurance policies and health care available in Connecticut. It requires the Health Reinsurance Association to administer the clearinghouse within available appropriations.

The act makes changes in the laws related to small employer health insurance plans. It redefines “small employer” and “eligible employee.” By doing so, it broadens the scope of certain laws by including part-time employees working at least 20 hours a week and limits the laws by excluding seasonal employees. For the purposes of determining if an employer is a small employer, the act prohibits the employer from counting a person working fewer than 30 hours a week as an eligible employee.

The act requires an insurer or producer marketing small employer group health insurance plans to offer a small employer, upon its request, a premium quote for covering employees working at least (1) 30 hours a week or (2) 20 hours a week.

The act also makes technical and conforming changes.

**EFFECTIVE DATE: July 1, 2010 for the Connecticut Clearinghouse and January 1, 2011 for the small employer provisions.**

**Public Act 10-5 (House Bill 5006)**

**An Act Concerning the Legislative Commissioners’ Recommendations for Technical Revisions and Minor Changes to the Insurance and Related Statutes**

*(Signed by Governor 5/5/2010)*

This act makes changes in various insurance and transportation statutes. It:

1. broadens the applicability of several health insurance benefits;
2. specifies penalties for, and expands the Department of Motor Vehicles (DMV) commissioner's authority regarding, violations of the motor vehicle repair shop notice requirements;
3. makes the insurance commissioner the agent to receive legal service of process for captive insurance companies domiciled in Connecticut if a registered agent cannot be found with reasonable diligence at the registered office;
4. requires all Connecticut-domiciled captive insurers, not just those formed as a corporation, to file a certificate of general good and articles of incorporation, if applicable, with the secretary of the state;
5. resolves a statutory conflict within the license expiration and renewal requirements for life settlement producers and brokers; and
6. makes other minor, technical, and conforming changes.

**EFFECTIVE DATE: Upon passage, except for the provisions extending the applicability of certain insurance benefit requirements, which are effective January 1, 2011.**

§§ 20-21, 23-24, 27-29, & 31-32 — HEALTH INSURANCE BENEFITS

The act broadens the applicability of several health insurance benefits required by law, as described below. (Due to federal law (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.)

*General Anesthesia Relating to Dental Services (§§ 20 & 27)*

The act requires individual and group health insurance policies amended in Connecticut on or after January 1, 2011 to cover medically necessary general anesthesia, nursing, and related hospital services provided to patients with (1) complex dental conditions that require procedures to be performed in a hospital or (2) developmental disabilities that place them at serious risk. The law already requires policies delivered, issued, renewed, or continued in Connecticut to cover these services.

Both the act and existing law apply to policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including coverage under an HMO plan.

*Ostomy Appliances and Supplies (§§ 21 & 28)*

The act requires individual and group health insurance policies amended in Connecticut on or after January 1, 2011 to cover medically necessary ostomy appliances and supplies, including collection devices, irrigation equipment and supplies, and skin barriers and protectors, up to \$1,000 annually. The law already requires policies delivered, issued, renewed, or continued in Connecticut to cover ostomy-related supplies.

Both the act and existing law apply to policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including coverage under an HMO plan.

*Bodily Injury (§§ 23 & 29)*

The act prohibits individual and group health insurance policies continued in Connecticut on or after January 1, 2011 from excluding coverage for a bodily injury solely because it was caused by a work-related accident to a person who is not covered by the workers' compensation law. The law already applies to policies delivered, issued, amended, or renewed in Connecticut.

Both the act and existing law apply to (1) individual or group health insurance policies that cover (a) basic hospital expenses; (b) basic medical-surgical expenses; (c) major medical expenses; (d) accident only coverage; or (e) hospital or medical services, including coverage under an HMO plan, and (2) individual health insurance policies that provide limited benefit health coverage.

*Treatment of Tumors and Leukemia and Related Benefits (§§ 24 & 31)*

The act requires individual and group health insurance policies renewed, amended, or continued in Connecticut on or after January 1, 2011 to provide certain benefits for the treatment of tumors and leukemia, reconstructive surgery, nondental prosthesis, chemotherapy, and wigs for chemotherapy patients. The law already requires policies issued or delivered in Connecticut to provide these benefits.

Coverage must be subject to the same terms and conditions applicable to other policy benefits. But the policy must provide at least a yearly benefit of \$500 for the surgical removal of tumors; \$500 for reconstructive surgery; \$500 for outpatient chemotherapy;

\$350 for a wig; and \$300 for a nondental prosthesis, unless the prosthesis is due to the surgical removal of breasts because of tumors, in which case the yearly benefit must be at least \$300 for each breast.

Both the act and existing law apply to (1) individual or group health insurance policies that cover (a) basic hospital expenses; (b) basic medical-surgical expenses; (c) major medical expenses; or (d) hospital or medical services, including coverage under an HMO plan, and (2) individual health insurance policies that provide limited benefit health coverage.

*Continuation of Coverage (§ 32)*

The act requires group health insurance policies amended in Connecticut on or after January 1, 2011, regardless of the number of insureds, to contain state continuation of coverage (“mini-COBRA”) provisions. The law already requires policies delivered, issued, renewed, or continued in Connecticut to contain those provisions.

Both the act and existing law apply to group health insurance policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) hospital confinement indemnity coverage; (4) major medical expenses; or (5) hospital or medical services, including coverage under an HMO plan

**§§ 48-50 — MOTOR VEHICLE REPAIR SHOP NOTICE REQUIREMENT**

The act allows the DMV commissioner to impose penalties for violations of the motor vehicle repair shop notice requirements under PA 08-146 (see BACKGROUND). It authorizes the commissioner to suspend or revoke a repair shop's license, fine the shop up to \$1,000 for each violation, or both. In addition to, or in lieu of these penalties, the commissioner may order the licensee to make restitution to an aggrieved customer. By law, the commissioner may impose these penalties for violations of other repair shop laws.

By law, a repair shop customer may waive, in writing, his or her right to a repair estimate. The act prohibits a repair shop from using waivers to evade its repair shop notice requirements. The law already prohibits waivers to evade duties under other repair shop laws.

The act authorizes the DMV commissioner to conduct investigations and hearings regarding a repair shop's compliance with the notice requirements. He currently has this authority with respect to other motor vehicle dealer and repairer laws. The act also allows the attorney general, at the commissioner's request, to seek a restraining order requiring a repair shop to cease violating PA 08-146, a power he has with respect to other repair shop laws.

**§§ 2, 5, & 6 — CAPTIVE INSURERS**

The act names the insurance commissioner the agent to receive legal service of process for captive insurance companies domiciled in Connecticut if a registered agent cannot be found with reasonable diligence at the captive's registered office. By law, the

commissioner is already the agent for captive insurers domiciled outside of Connecticut that do business here.

The act requires a captive insurance company formed as a reciprocal insurer or limited liability company to give the secretary of the state, along with any required filing fee, a certificate of general good from the insurance commissioner and the insurer's articles of incorporation, if applicable. By law, a captive formed as a corporation must already do this. The act also makes technical and conforming changes in the captive laws.

#### §§ 13 & 15 — LIFE SETTLEMENT STATUTES

The act resolves a statutory conflict within the license expiration and renewal requirements for life settlement producers and brokers. PA 08-175 both retained the prior law's requirements and added new, conflicting ones. This act retains the prior law, specifying that provider and broker licenses expire on March 31 in each year, but may be renewed annually. If a provider or broker fails to pay the renewal fee on time, the commissioner must revoke his or her license, unless he or she pays within five days after the commissioner sends a written notice of nonrenewal, by first class mail, after March 31.

The act deletes the following provisions: (1) the term of a (a) producer license is equal to that of a domestic stock life insurance company (annual renewal) and (b) broker license is equal to that of an insurance producer (if an individual, renewal is every other year on the person's birth date, and if an entity, February 1 of even-numbered years) and (2) licenses must be renewed on their anniversary dates and failure to pay the renewal fee by that date results in license expiration.

The act deletes another provision from PA 08-175. The provision specified that if a broker verifies the existence of a life insurance policy, then a life settlement provider is deemed to have fulfilled the law's extensive disclosure requirements.

By law, a life settlement provider, within 20 days after a life insurance policy owner executes a life settlement contract, must give the insurer that issued the policy written notice that the policy has become subject to a life settlement contract. The act requires the provider to send the notice with a copy of the insured's (1) required medical records release form and (2) application for the life settlement contract, instead of with optional disclosure documents.

#### § 26 — PREMIUM PAYMENTS FOR TERMINATED EMPLOYEES

PA 09-126 allows an employer, with certain exceptions, to 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 except layoff. This act adds another exception: relocation or closing of a "covered establishment" (i. e. , an industrial, commercial, or business facility that employs, or has employed in the preceding 12 months, 100 or more people).

The act specifies that an employee's or dependent's right to continue coverage after a covered establishment relocates or closes is not affected by PA 09-126. By law, when a covered establishment relocates or closes, the employer must pay for continued insurance coverage for affected employees and dependents for 120 days or until the employee becomes eligible for other coverage (CGS § 31-51o).

#### § 52 — NOTICE TO COURTS AND POLICE DEPARTMENTS

The act eliminates the class D felony penalty (see Table on Penalties) for the insurance commissioner's failure to provide courts and police departments a list of surety bail bond agents or changes to the list.

### **Public Act 10-13 (House Bill 5219)** **An Act Extending State Continuation of Health Insurance Coverage** *(Signed by Governor 5/5/2010)*

This act extends the period for which certain people and their dependents may continue group health insurance under the state's "mini-COBRA" law from 18 to 30 months. To qualify for the continued coverage, the person must have experienced a specified qualifying event, including a layoff, reduced hours, leave of absence, or termination of employment for other than death or gross misconduct.

The act's extended coverage provision applies to people who are already continuing coverage due to those qualifying events and people who elect to do so on and after the act's passage (i.e., May 5, 2010). By law, unchanged by the act, spouses and dependents who are continuing coverage for any other reason (e. g. , death of employee or divorce) are permitted to continue coverage for 36 months under federal COBRA.

The act requires each insurer and HMO that has issued a group health insurance policy subject to the continuation requirements, in conjunction with their group policyholders, to provide notice of the extended coverage period to affected people within 60 days of the act's passage (i. e. , notice must be sent by July 4, 2010). Group policyholders include those with fewer than 20 employees.

The act also makes technical and conforming changes.

**EFFECTIVE DATE: Upon passage**

**See Insurance Department Bulletin HC-77 for further details.**

#### **BACKGROUND**

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) and state "mini-COBRA" provide certain former employees, retirees, spouses, and children with the right to temporarily continue coverage under an employer's group health plan after their coverage would otherwise end, so long as the covered person pays the required premiums. A person may be required to pay the full premium and administrative costs, up

to 102% of the full group rate premium. Federal COBRA applies to employer groups with 20 or more employees. Connecticut law applies to all groups regardless of size (CGS §§ 38a-538, 546, and 554). The federal government currently offers a 65% premium subsidy to certain people who have recently lost employment.

Federal COBRA establishes the time period for which coverage must continue for a qualified person, but a plan or state may provide longer periods. Federal COBRA requires coverage to extend for 18 months when a person would otherwise lose coverage because of job loss or reduced work hours. 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.

In addition, state law permits an employee and 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.

**Public Act 10-19 (House Bill 5303)**

**An Act Requiring Reporting of Certain Health Insurance Claims Denial Data**

*(Signed by Governor 5/5/2010)*

This act adds claims denial data for the prior calendar year to the information that managed care organizations (MCOs) must report to the insurance commissioner annually by May 1. (MCOs include insurers, HMOs, hospital or medical service corporations, or other organizations issuing managed care plans in Connecticut.) By law, an MCO that fails to file data on time must pay a late fee of \$100 per day for each day late (CGS § 38a-478b).

The act requires the commissioner to post the claims denial information on the Insurance Department's website and include it in the Consumer Report Card on Health Insurance Carriers in Connecticut, which the department publishes annually by October 15.

The act also makes technical and conforming changes.

**EFFECTIVE DATE: July 1, 2010, except the consumer report card provision is effective January 1, 2011.**

**CLAIMS DENIAL DATA REPORTING**

The act requires MCOs to report claims denial data to the insurance commissioner annually by May 1, in a format the commissioner prescribes. The data is for the prior calendar year and must relate to Connecticut residents covered by managed care plans. The data must include the number of (1) claims received, (2) claims denied, (3) denials that were appealed, and (4) denials that were reversed on appeal. The data must also include (1) the reasons for the denials, including “not a covered benefit,” “not medically

necessary,” and “not an eligible enrollee”; (2) the number and percentage of times each reason was used; and (3) other information the commissioner deems necessary.

**Public Act 10-24 (House Bill 5235)**

**An Act Requiring the Providing of Certain Information Upon Certain Denials of Health Insurance Coverage**

*(Signed by Governor 5/5/2010)*

This act requires certain health insurers who deny coverage of a requested service because it is not (1) medically necessary or (2) a covered benefit to notify the insured of his or her ability to contact the Office of the Healthcare Advocate if the insured believes he or she has been given erroneous information. Insurers must also provide the insured with contact information for the healthcare advocate's office.

The act applies to each insurer, health care center, hospital or medical service corporation, or other entity that delivers, issues, renews, amends, or continues in Connecticut individual or group health insurance policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (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.

The act also imposes a 45-day coverage determination and notice requirement on any of the above entities that continue an individual or group health insurance policy in Connecticut. The law already requires this for individual and group policies that are delivered, issued, amended, or renewed in the state.

**EFFECTIVE DATE: January 1, 2011**

**Public Act 10-59 (Senate Bill 17)**

**An Act Concerning Health Care Provider Rental Network Contract Arrangements**

*(Signed by Governor 5/18/10)*

The law allows entities that contract with health care providers (i.e., “contracting entities”) to give third parties (i.e., “covered entities”) access to the providers' services, rates, or fees under certain conditions (CGS § 42-490, *et seq.* ). This act makes a violation of the law an unfair or deceptive insurance practice and authorizes the insurance commissioner to adopt regulations. It also (1) requires a contracting entity to update routinely and at least every 90 days its list of covered entities, which must be available to providers by law; (2) establishes requirements for a covered entity that subsequently gives others access to a provider's services, rates, or fees; and (3) permits a health care provider to file legal actions against contracting and covered entities.

**EFFECTIVE DATE: October 1, 2010**

## CONTRACTING ENTITY

By law, each contracting entity that sells, leases, rents, assigns, or grants access to a health care provider's services, rates, or fees must:

1. give a provider who requests it, when first contracting with him or her, a list of all known covered entities to which it may give access to the provider's services, rates, or fees and
2. maintain a website or toll-free number through which a provider can obtain a listing of covered entities having access to his or her services, rates, or fees.

The act requires a contracting entity to update its list of covered entities routinely and at least every 90 days.

## COVERED ENTITY

The act establishes requirements for a covered entity that subsequently sells, leases, rents, assigns, or grants access to a provider's services, rates, or fees to another third party.

Specifically, such a covered entity must:

1. maintain a website or toll-free number through which a provider can obtain a listing of entities having access to his or her services, rates, or fees and
2. when giving access, inform the contracting entity and its directly-contracted providers of its website address or toll-free number.

The act requires a covered entity to update the list of entities to which it has granted access to providers' services, rates, or fees routinely and at least every 90 days.

## BACKGROUND

### *Connecticut Unfair Insurance Practice Act (CUIPA)*

The law prohibits engaging in unfair or deceptive insurance acts or practices. CUIPA authorizes the insurance commissioner to issue regulations, conduct investigations and hearings, issue cease and desist orders, ask the attorney general to seek injunctive relief in Superior Court, impose fines, revoke or suspend licenses, and order restitution.

Fines may be up to (1) \$5,000 per violation to a \$50,000 maximum or (2) \$25,000 per violation to a \$250,000 maximum in any six-month period if knowingly committed. The law also imposes a fine of up to \$50,000, in addition to or in lieu of a license suspension or revocation, for violating a cease and desist order (CGS § 38a-817).

## **Public Act 10-63 (Senate Bill 50)**

### **An Act Concerning Oral Chemotherapy Treatments**

*(Signed by Governor 5/18/2010)*

This act requires certain health insurance policies that cover intravenously and orally administered anticancer medications prescribed by a licensed practitioner with prescribing authority to cover the orally administered medication on at least as favorable a basis as the intravenously administered medication. It prohibits insurers, HMOs, medical and hospital service corporations, and fraternal benefit societies from

reclassifying anticancer medications or increasing the patient's out-of-pocket costs for the medications as a way to comply.

The act also broadens the applicability of several health insurance benefits required by law, including treatment of tumors and leukemia, reconstructive surgery, nondental prosthesis, chemotherapy, and wigs for chemotherapy patients. It does this by requiring all policies renewed, amended, or continued in Connecticut to include the benefits. Policies delivered or issued here already must include them.

**EFFECTIVE DATE: January 1, 2011**

#### EXPANDED APPLICABILITY OF REQUIREMENTS

The act requires health insurance policies renewed, amended, or continued in Connecticut to provide coverage for:

1. the surgical removal of tumors and related outpatient chemotherapy;
2. treatment of leukemia, including outpatient chemotherapy;
3. reconstructive surgery, including on a breast on which a mastectomy was performed and a nondiseased breast for symmetry (such as augmentation or reduction mammoplasty and mastopexy);
4. nondental prosthesis, including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such a prosthesis;
5. an oncologist-prescribed wig for a patient with hair loss resulting from chemotherapy; and
6. if a group health insurance policy, medically necessary removal of breast implants that were implanted before July 2, 1994.

Coverage must be subject to the same terms and conditions applicable to other benefits under the policy. But the policy must provide at least a yearly benefit of: (1) \$500 each for the surgical removal of tumors, reconstructive surgery, and outpatient chemotherapy; (2) \$350 for a wig; (3) \$300 for a nondental prosthesis, unless the prosthesis is due to the surgical removal of breasts because of tumors, in which case the yearly benefit must be at least \$300 for each breast; and (4) if a group policy, \$1,000 for a breast implant removal.

Coverage must be provided for the reasonable cost of reconstructive breast surgery.

By law, policies issued or delivered in Connecticut already must include these benefits.

#### APPLICABILITY OF THE ACT

The act applies to individual and 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; or (4) hospital or medical services, including coverage under an HMO plan. It also applies to individual health insurance policies that provide limited benefit health coverage.

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

**Public Act 10-65 (Senate Bill 141)**  
**An Act Requiring Disclosure of Offsets in Group Long-Term Disability Insurance Policies**  
*(Signed by Governor 5/18/2010)*

Group long-term disability (LTD) policies usually include a “benefit offset.” State law prohibits an insurer that issues, delivers, renews, or amends a group LTD policy in Connecticut from including an “offset proviso.” A “benefit offset” is a policy provision that reduces the amount of benefits available under the policy if benefits are also available from other sources (e. g. , Social Security). An “offset proviso” is a policy provision that allows the insurer to reduce its liability by any increase in benefits available from the other sources that occurs after a claim begins under the policy. This act specifies that the increase in other benefits is limited to cost of living increases. The act requires an insurer, for each group LTD policy that contains a benefit offset, to disclose specified information to the policyholder. The act requires each policyholder to provide the disclosed information to each individual eligible for LTD benefits. The act also extends its provisions to group LTD policies continued in Connecticut and makes technical changes.

**EFFECTIVE DATE: January 1, 2011**

**REQUIRED DISCLOSURE**

For each group LTD policy with an offset, the insurer must disclose, in a conspicuous manner in at least 14-point bold face type in a separate document:

1. that the policy contains an offset;
2. that the offset functions to limit payments to a person insured under the policy, taking into account benefits the person may receive from other sources, including Social Security disability benefits;
3. what other categories of benefits the policy offsets;
4. the income percentage the policy covers and any maximum dollar limit;
5. at least one example of how the offset works; and
6. that an eligible individual who does not want an offset may contact an insurance agent or company for an individual policy.

**Public Act 10-118 (Senate Bill 400)**  
**An Act Concerning Insurance Reimbursement Payments to School-Based Health Centers**  
*(Signed by Governor 6/7/2010)*

This act requires each Connecticut-licensed health insurer, at the request of one or more school-based health centers (SBHCs), to offer to contract with the center or centers to reimburse enrollees for covered health services. This offer must be made on terms and conditions similar to contracts offered to other health care service providers.

**EFFECTIVE DATE: Upon passage**

**Public Act 10-163 (House Bill 5004)**  
**An Act Concerning Transparency in Health Insurance Claims Data**  
*(Signed by Governor 6/7/2010)*

This act requires an insurer or similar entity to disclose to a municipal employer certain information about its group insurance policy. It defines “employer” as a town; city; borough; or school, taxing, or fire district that has more than 50 employees. The information relates to services used, claims paid, premiums paid, and the number of people covered under the policy.

The act requires the insurer or entity to provide the information (1) at the employer's request, (2) for the shorter of the most recent 36 months or entire coverage period ending within 60 days before making the request, and (3) in a specified format. It specifies that the insurer does not have to provide information more than once in a 12-month period. The bill makes information disclosed to an employer exempt from disclosure under the Freedom of Information Act.

The act requires an employer to use the information it receives only for the purposes of obtaining competitive quotes for group insurance or to promote wellness initiatives for employees.

**EFFECTIVE DATE: Upon passage**

*APPLICABILITY OF ACT*

The act applies to each insurer, health care center (i. e. , HMO), hospital or medical service corporation, or other entity that delivers, issues, renews, amends, or continues any group health insurance policy in Connecticut that covers (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including coverage under an HMO plan.

*INFORMATION AN INSURER MUST DISCLOSE*

The act requires the insurer or entity to disclose, at an employer's request:

1. complete and accurate medical, dental, and pharmaceutical utilization data, as applicable;
2. total claims paid and claims paid by year, practice type, and service category, for in-network and out-of-network providers;
3. premiums the employer paid by month; and
4. the number of people insured under the policy by month and coverage tier, including single, two-person, and family.

The act requires the insurer or entity to disclose only information that (1) cannot be used to identify an individual and (2) is disclosable under the federal Health Insurance Portability and Accountability Act (HIPAA) or its regulations.

*Utilization Data*

The act defines “utilization data” as the aggregate number of (1) procedures performed for the employer's covered employees, by practice type and service category, and (2) prescriptions filled for those employees, by prescription drug name.

### *Claims Paid*

The act defines “claims paid” as the amounts paid for the employer's covered employees' medical services and supplies and prescriptions. It excludes expenses for stop-loss coverage, reinsurance, enrollee educational programs, other cost containment programs or features, administrative costs, and profit.

### *REQUIRED FORMAT*

The insurer or other entity must provide the information (1) in a written report, (2) electronically in a secure e-mail or through a file transfer protocol site, or (3) through a secure website or website portal the employer can access.

### *CONFIDENTIALITY*

The act makes information disclosed to an employer exempt from disclosure under the Freedom of Information Act. But it allows the employer to provide claim information to a collective bargaining unit to fulfill its statutory duties.

### *SUBPOENA OR SIMILAR DEMAND*

If the information disclosed to an employer is the subject of a subpoena or similar demand as part of a court proceeding, the act requires the employer to immediately notify the entity that disclosed the information (e. g. , the insurer or HMO). The act grants the entity standing to file an application or motion with the court to quash or modify the subpoena. If the entity does so, the act requires the court to stay the subpoena without penalty to the parties until a hearing can be held and the court enters an order.

**Acts of Direct Interest to the Insurance Department**  
**Property and Casualty**

**Public Act 10-7 (House Bill 5014)**

**An Act Concerning Automobile and Personal Risk Insurance**

*(Signed by Governor 5/5/2010)*

This act codifies and amends the Insurance Department's guidelines on how insurers can use a person's credit history when underwriting or rating a personal risk insurance policy (e.g., homeowners or private passenger nonfleet automobile (auto)). It also makes numerous changes in laws relating to auto insurance. Specifically, the act:

1. requires an auto insurer to allocate certain expenses on a “flat dollar basis” when determining policy rates;
2. requires auto insurance rating plans that use territorial classifications to assign a weight of 75% to individual loss-costs and 25% to state wide average loss-costs, as currently required by Insurance Department guidelines;
3. requires the insurance commissioner to adopt regulations regarding underwriting and rating auto insurance policies;
4. requires an insurer that cancels an auto insurance policy in accordance with law to give written cancellation notice to any lienholder listed in the insurer's records as having a legal interest in the motor vehicle (§ 5);
5. requires a person whose vehicle has been impounded for not having the required registration to present a valid registration and current auto insurance identification card to regain possession of the vehicle (§ 6);
6. allows an auto insurer to use any publicly available auto industry source approved by the commissioner to determine a totaled vehicle's retail value;
7. requires an auto insurer to give a claimant details on how it calculated a totaled vehicle's loss value, including how to dispute the settlement through the Insurance Department; and
8. increases, from 10% to 15% per year, the interest an arbitrator the Insurance Department uses to resolve a settlement dispute between an auto insurer and claimant must award when the decision favors the consumer (§ 8).

**EFFECTIVE DATE: January 1, 2011, except for the financial history measurement program requirements, which are effective July 1, 2011, and provisions regarding impounded vehicles and notices to lienholders of auto policy cancellations, which are effective October 1, 2010.**

§§ 2-4 — FINANCIAL HISTORY MEASUREMENT PROGRAM AND USE OF CREDIT HISTORY

The act permits an insurer to use a “financial history measurement program” only when underwriting or developing rates for new personal risk insurance policies. It prohibits an insurer from using credit history when renewing a policy, unless (1) the policyholder asks

or (2) using the program reduces the insured's premium under the insurer's filed rates and rules.

The act defines “financial history measurement program” as a program that uses an insurance applicant's credit history to measure his or her risk of loss (i. e. , filing claims). It defines “credit history” as credit-related information (1) derived from or found in a credit report or credit-scoring program or (2) provided in an application for personal risk insurance.

#### *Program Filing Requirements*

The act requires an insurer using a financial history measurement program to underwrite or rate policies to file the program with the insurance commissioner. The filing must:

1. include the program's description, rules, and procedures;
2. identify the characteristics the program uses from which the insurer derives a measurement; and
3. explain the impact of credit information and public records on insurance rates over time.

The act prohibits the program from (1) unfairly discriminating among applicants or (2) producing rates that are excessive for the risk assumed. This filing is considered a trade secret and thus is exempt from disclosure under the Freedom of Information Act.

The act requires an insurer using a financial history measurement program to also give the commissioner documentation demonstrating (1) the correlation between the program and the expected risk of loss and (2) how the program affects consumers (a) in urban versus nonurban territories and (b) of different ages. The act authorizes the commissioner to request that an insurer provide a financial history measurement for a set of test examples reflecting various characteristics.

#### *Disclosure to Insurance Applicant*

When anyone applies for a policy, the act requires an insurer to disclose to the person that the company may use his or her credit history in the underwriting or rating process. The insurer must also disclose, at the same time, that the applicant may request, in writing, that the insurer consider an extraordinary life circumstance during this process or during a review of a rate quote requested by such applicant, if the applicant's credit history has been harmed by such a circumstance that occurred within three years before the application. The insurer must make these disclosures in writing, by e-mail or telephone, or orally.

The insurer also must give each policy purchaser a written disclosure, by the date the policy is issued, that:

1. lists the insurer's name, address, telephone number, and toll-free telephone number, if any;
2. includes a detailed statement that explains how the insurer will use credit information to underwrite or rate the policy; and
3. summarizes consumer protections regarding the use of credit, in a form determined by the commissioner.

The disclosure must be printed in reasonably conspicuous type and be provided electronically, by mail, or by hand delivery.

### *Prohibited Practices*

The act prohibits insurers from using the following characteristics of an applicant or an insured in its financial history measurement program:

1. the number of credit inquiries in a credit report or credit history;
2. the use of a particular type of credit, debit, or charge card;
3. the total available line of credit;
4. any disputed credit information being reviewed by a credit reporting company, so long as the information is identified as being disputed in the report or history;
5. debt the applicant incurred from financing hospital or medical expenses; and
6. the lack of credit history, unless the insurer treats the applicant or insured as if he or she had neutral credit information as defined by the insurer.

A financial history measurement program must give the same weight to an applicant's or insured's purchase or financing of a specific item regardless of the type of item purchased or financed.

### *Extraordinary Life Circumstances*

The act requires an insurer to consider during its underwriting or rating process or during a review requested by an applicant, an applicant's extraordinary life circumstance. The insurer must do this on an applicant's written request if a circumstance occurred within three years before the application date. If the insurer determines that the applicant's credit history has been adversely impacted by an extraordinary life circumstance, it must grant a reasonable exception to its rates, rating classifications, or underwriting rules for the applicant.

The act defines an "extraordinary life circumstance" as:

1. a catastrophic illness or injury;
2. a divorce;
3. the death of a spouse, child, or parent;
4. the involuntary loss of employment for more than three consecutive months;
5. identity theft;
6. total or other loss that makes a home uninhabitable;
7. other circumstances the commissioner identifies in regulations adopted in accordance with law; or
8. any other circumstance the insurer chooses to recognize.

The act permits an insurer to require the applicant to provide reasonable, independently verifiable documentation of the extraordinary circumstance and its effect on the applicant's credit report or credit history. It requires an insurer to keep confidential any documentation or information it obtains.

If the insurer grants an exception, it must (1) consider only credit information not affected by the extraordinary circumstance or (2) treat the applicant as if he or she had neutral or better-than-neutral credit information, as defined by the insurer.

An insurer may not be deemed to be out of compliance with any provision of the statutes or regulations concerning underwriting, rating, or rate filing solely based on granting an exception.

#### *Adverse Actions Due to Credit History*

The act requires an insurer that takes an adverse action due in part to an insured's or applicant's credit report to disclose this to the person and tell him or her about (1) the right to obtain a free credit report, and how to do so; (2) the types of extraordinary life circumstances described above; and (3) how an applicant may inform the insurer of an extraordinary life circumstance and submit any required documentation in order to seek an exception.

Under the act, an “adverse action” includes:

1. denying coverage or offering restricted coverage,
2. offering a higher rate,
3. assigning a person to a higher rate tier or higher-priced company within an insurer group, or
4. any other action that adversely impacts an insured or applicant due to the insurer's financial history measurement program.

#### *Cannot Deny Insurance Solely Due to Credit History*

The act prohibits an insurer from denying, cancelling, or not renewing a personal risk insurance policy based solely on a person's (1) credit history or rating or (2) lack of credit history. The act specifies that it does not deem an insurer to have declined, cancelled, or not renewed a policy if coverage is available to the person through an affiliated insurer.

#### *Report to Commissioner*

The act allows the commissioner to require an insurer to report to him, once the insurer's financial history measurement program has been in effect for two years. The report must include information demonstrating that the program results in rates that are supported by the data and not unfairly discriminatory. It must also include an analysis of consumer complaints the insurer received because it used a financial history measurement program. The analysis must identify the basis for the complaints and any action the insurer took as a result.

### **§ 1 — RATING PLANS**

#### *Allocating Expenses on a Flat-Dollar Basis*

The act requires an auto insurer to allocate certain expenses on a “flat-dollar basis” to a policy's base rate. It requires an insurer to add a flat-dollar amount to the base rate for (1) at least 90% of general expenses, including administration and overhead costs; (2) at least 90% of acquisition costs for marketing and agent field offices, which may be allocated over the expected life of the insurer's policies; and (3) miscellaneous taxes, licenses, and fees. It requires adding the flat-dollar amount after the insurer has applied any classification factors to the base rate.

It prohibits insurers from allocating as flat-dollar amounts to the base rate (1) producer commissions, (2) premium taxes, (3) underwriting profits, and (4) contingencies.

By law, an insurer may group risks by classifications and modify base rates for a person's individual characteristics as described in the rating plan it files with the commissioner.

### *Territorial Rating*

The term “territorial rating” refers to an insurer's practice of factoring in, when setting auto insurance rates, the principal place where a driver garages his or her vehicle. The Insurance Department, through administrative guidelines, currently requires a 75%/25% weighting of territory to statewide experience. This means that the base rate for an auto insurance policy must give 75% weight to the territory's loss-cost data and 25% weight to the statewide average loss-cost data.

The act codifies these guidelines by requiring that auto insurance rating plans using territorial classifications assign a weight of 75% to individual territorial loss-cost indication and 25% to the state-wide average loss-cost indication.

### *Regulations*

Prior law authorized the commissioner to adopt regulations concerning rating plans and the underwriting, classification, or rating of risks for auto insurance in Connecticut. The act instead requires him, by January 1, 2012, to adopt by regulation the Insurance Department's “most current guidelines and bulletins” regarding the underwriting, classification, or rating of auto insurance risks in Connecticut, including those regarding territorial rating.

## **§ 7 — SETTLEMENT AMOUNT ON TOTALED VEHICLE**

By law, a vehicle is a “constructive total loss” if the cost to repair or salvage it, or both, equals or exceeds the vehicle's total value at the time of loss. Previously, when an insurer declared a covered, damaged vehicle a constructive total loss, the insurer had to calculate the vehicle's value for determining the settlement amount by using at least the average of the retail values given by (1) the National Automobile Dealers Association (NADA) used car guide and (2) one other automobile industry source that the insurance commissioner approved for such use. The act allows the insurer to use any other publicly available automobile industry source the commissioner approves for such use rather than the NADA guide as one of the two sources for determining the vehicle's average retail value.

The act also requires the insurer to give the claimant, by the time it pays the settlement amount:

1. a detailed copy of its calculation of the vehicle's constructive total loss value;
2. if applicable, a copy of any valuation report provided to the insurer by any automobile industry source that is not publicly available; and
3. a written notice disclosing that the claimant may dispute the settlement by contacting the Insurance Department.

The insurer's written notice must include in its final paragraph in at least 12-point type the following statement: “If you do not agree with this valuation, you may contact the Consumer Affairs Division within the Insurance Department.” The notice must give the division's address and toll-free phone number and the department's Internet address.

**Public Act 10-53 (Senate Bill 190)**  
**An Act Concerning a Four-Hour Accident Prevention Course for Older Drivers**  
*(Signed by Governor 5/8/2010)*

By law, a driver age 60 or older is eligible for an automobile insurance premium discount for successfully completing an accident-prevention course approved by the Department of Motor Vehicles (DMV). This act requires the course to be four hours long.

Prior law required the DMV commissioner to adopt regulations about the course, including the number of hours of classroom instruction required. The act removes his authority to regulate the length of the course.

**EFFECTIVE DATE: October 1, 2010**

*Auto Insurance Premium Discount*

The premium discount, which is effective at the policy's next renewal, must be at least 5% and apply for at least 24 months. The driver must complete the DMV-approved course within the year before he or she applies for an initial discount. For any future discount, the driver must complete a course within one year before the current discount expires.

**Acts of Direct Interest to the Insurance Department**  
**Consumer Services/Legal**

**Public Act 10-79 (House Bill 5141)**  
**An Act Concerning the Handling of Property Claims by Public Adjusters**  
*(Signed by Governor 5/26/2010)*

This act redefines a “public adjuster” to specify the range of services one is allowed to perform.

Prior law defined a “public adjuster” as any person or company that adjusts loss or damage caused by fire or other hazards under an insurance policy on behalf of the insured person. The act, instead, defines it as a person or company that, on behalf of an insured person and for compensation or anything of value, (1) prepares, documents, and submits a first-party property claim to an insurance company for loss or damage covered under a personal or commercial risk insurance policy or (2) negotiates, adjusts, or effects a claim settlement. As under existing law, the act also includes in the definition any person or company that (1) advertises or solicits business as a public adjuster or (2) holds himself or itself out to the public as engaging in adjusting activities.

The act prohibits a public adjuster from soliciting an insured person between 8: 00 p. m. and 8: 00 a. m. This restriction is in current regulation.

By law, anyone who acts as a public adjuster without a license issued by the insurance commissioner is subject to a \$10,000 fine, up to three months in prison, or both (CGS § 38a-725). The act also makes technical and conforming changes.

**EFFECTIVE DATE: October 1, 2010**

**Public Act 10-127 (House Bill 5113)**

**An Act Concerning Billing for Services Covered by Long-Term Care Insurance by Managed Residential Communities**

*(Signed by Governor 6/7/2010)*

This act requires a managed residential community (MRC) to help a resident, at his or her request, prepare and submit claims on a long-term care insurance policy. The resident must direct the insurer in writing to provide to the MRC (1) information about the resident's eligibility for insurance benefits and payments and (2) a copy of the insurer's decision on a benefit claim when it informs the resident of its decision. The act exempts this kind of assistance from the prohibition against MRCs controlling or managing residents' financial affairs.

The act prohibits insurers and other entities that deliver, issue for delivery, renew, continue, or amend individual or group long-term care policies in Connecticut from refusing to accept or reimburse claims prepared or submitted by an MRC solely because of the MRC's assistance. And it requires them to give the MRC the information a resident directs them to provide and a copy of any claims decision.

**EFFECTIVE DATE: July 1, 2010**

**Public Act 10-131 (House Bill 5295)**

**An Act Concerning the Purchasing of Prescription Drugs by Nonstate Public Employers**

*(Signed by Governor 6/10/2010)*

This act requires the comptroller to (1) offer nonstate public employers the option to purchase prescription drugs through the state's bulk purchasing authority under PA 09-206 and (2) establish procedures for doing this. The prescription drugs must be purchased for the employers' employees, employees' dependents, or retirees. The act defines "nonstate public employer" as (1) a municipality or other state political subdivision, including a board of education, quasi-public agency, or public library and (2) the Teachers' Retirement Board.

In making the offer, the act requires the comptroller to offer nonstate public employers the option of purchasing prescription drugs through the State Employees' Bargaining Agent Coalition (SEBAC) collective bargaining agreement with the state, but only if the Health Care Cost Containment Committee (HCCCC) gives the comptroller written notice that doing so is consistent with that agreement. (HCCCC is a state labor and management committee that exists under agreement with SEBAC.) The act permits the comptroller to proceed without the written notice if she establishes a prescription drug purchasing program for nonstate public employers that is separate from the program for state employees.

The act requires nonstate public employers to pay the full cost of their own claims and prescription drugs. The act authorizes the comptroller to offer a nonstate public employer participating in the prescription drug purchasing program the option of purchasing stop-loss coverage from an insurer at a rate she negotiates.

Lastly, the act permits two or more nonstate public employers to join together to purchase prescription drugs for their employees, employees' dependents, and retirees. It specifies that such an arrangement does not constitute a multiple employer welfare arrangement (MEWA) as defined under federal law.

**EFFECTIVE DATE: Upon passage**

**Public Act 10-174 (House Bill 5424)**

**An Act Concerning Agreements Between Municipalities and Boards of Education for the Joint Purchase of Employee Health Insurance and the Disclosure of Certain Information Regarding Compensation for Services Provided by Insurance Producers**

*(Signed by Governor 6/8/2010)*

This act permits two or more municipalities or local or regional boards of education, or any combination of these, to enter into a written agreement to act as a single entity to provide employee medical or health care benefits under certain conditions. Existing law already permits municipalities to jointly perform any function that each has authority to perform separately.

The agreement is subject to the conditions of any union contract the municipality or board has with its employees. The act also requires the legislative body of a municipality to approve the agreement when certain conditions exist between the municipality and board of education.

The agreement must establish:

1. the group's membership,
2. the benefit plan duration,
3. payment requirements for the benefits,

4. procedures for a municipality or board of education to withdraw from the agreement, and
5. procedures for the group to terminate the benefit plan.

The act specifies that a group formed under its provisions is not (1) a multiple employer welfare arrangement (MEWA) as defined under the federal Employee Retirement Income Security Act of 1974 (ERISA) (see BACKGROUND) or (2) a “fictitious group.” (Insurance law prohibits a fictitious group organized for insurance rating purposes where differences in rates are based solely on membership in the group. But the prohibition does not apply to health insurance. )

The act requires that any insurance producer who sells, solicits, or negotiates insurance, on an insurer's behalf, with a municipality or a board of education to, at the municipality's or board's request, fully disclose in writing any fees or compensation the producer receives from the insurer for services under (1) the written memorandum required by existing law or (2) the 1940 Federal Investment Advisors Act.

**EFFECTIVE DATE: October 1, 2010**

### **Other Acts of Interest**

#### **Public Act 10-9 (House Bill 5138)**

#### **An Act Making Minor and Technical Revisions to Department of Consumer Protection Statutes**

*(Signed by Governor 5/5/2010)*

This act makes minor and technical changes to consumer protection statutes concerning (1) food labeling, (2) seal requirements for well-drillers, (3) Home Improvement Guarantee Fund payment requests, (4) license renewals, (5) Automotive Glass Work and Flat Glass Work Board members, (6) **proof of workers' compensation insurance**, (7) Department of Consumer Protection (DCP) exam requirements, and (8) charitable organizations.

**EFFECTIVE DATE: Upon passage**

**Only the Workers' Compensation insurance provision is summarized below.**

#### § 9 — EVIDENCE OF WORKERS' COMPENSATION INSURANCE

The act gives those applying for an initial DCP license or permit the option of providing the name of the insurer, insurance policy number, effective dates of coverage, and a certification that the information is truthful and accurate to prove they have workers compensation insurance. Under prior law, only renewal applicants could use this method. By law, they can also provide one of three different physical certificates showing they have the required insurance.

**Public Act 10-11 (House Bill 5201)**

**An Act Concerning Interest Penalties on Late Payment of Assessments to the Second Injury Fund**

*(Signed by Governor 5/5/2010)*

This act specifies that the penalty for overdue Second Injury Fund assessments from employers or insurers is 15% of the assessment or \$50, whichever is greater. Under prior law, it was unclear when an employer or insurer paid 15% or the \$50 minimum. The fund, administered by the state treasurer, provides workers' compensation coverage to workers whose employers failed to provide it. Employers, and insurers on behalf of employers, pay an annual assessment into the fund.

**EFFECTIVE DATE: Upon passage**

**Public Act 10-12 (House Bill 5204)**

**An Act Implementing the Recommendations of the Joint Enforcement Commission on Employee Misclassification**

*(Signed by Governor 5/5/2010)*

By law, any employer who misrepresents either the number of its employees or casts them as independent contractors to defraud or deceive an insurance company in order to pay lower workers' compensation insurance is (1) guilty of a class D felony (see Table on Penalties), (2) subject to a stop work order, and (3) liable to the Labor Department for a \$300 civil penalty. This act applies the same penalty to an employer who defrauds or deceives the state in the same way. The act also increases the civil penalty for this violation by specifying that each day of the violation constitutes a separate offense.

The act specifies that any employer who is fully insured for workers' compensation and fails to pay the required state assessments for (1) administration of the Workers' Compensation Commission and (2) administration and funding of the Second Injury Fund (SIF), is guilty of a class D felony and subject to a stop work order. By law, a self-insured employer who fails to make the same assessments is already subject to these penalties.

The SIF, which the state treasurer administers, is an employer-funded program that provides workers' compensation to employees whose employers did not provide it. By law and with few exceptions, employers must provide workers' compensation insurance for their employees.

**EFFECTIVE DATE: October 1, 2010**

**Public Act 10-32 (House Bill 5376)**  
**AN ACT CONCERNING THE REVISOR'S TECHNICAL CORRECTIONS TO THE GENERAL STATUTES**  
*(Signed by Governor 5/10/2010)*

This act makes technical changes to the general statutes.  
See Insurance Related changes in sections 116 through 124.

**EFFECTIVE DATE: Upon passage, except changes to probate provisions taking effect on January 5, 2011 are effective on that date.**

**Public Act 10-37 (House Bill 5282)**  
**An Act Concerning Firefighters, Police Officers and Workers' Compensation Claims Pertaining to Certain Diseases**  
*(Signed by Governor 5/18/2010)*

Under this act, a paid municipal or volunteer firefighter, municipal police officer, constable, or volunteer ambulance service member is eligible for workers' compensation benefits for diseases, including the following, if they arise out of and are in the course of employment: (1) hepatitis, (2) meningococcal meningitis, (3) tuberculosis, (4) Kahler's Disease (multiple myeloma), (5) non-Hodgkin's lymphoma, (6) prostate cancer, or (7) testicular cancer. As with all workers' compensation claims, the disease must result in death or temporary or permanent total or partial disability in order to be eligible for benefits (i. e. , it must cause at least some loss of work time). Since workers' compensation law already covers any disabling injury or illness that arises out of and in the course of employment, it is unlikely that this act has any legal effect.

**EFFECTIVE DATE: October 1, 2010**

**Public Act 10-50 (Senate Bill 149)**  
**An Act Concerning the Governor's Power to Modify or Suspend Statutes, Regulations or Other Requirements During a Public Health Emergency**  
*(Signed by Governor 5/18/2010)*

This act allows the governor, when she declares a civil preparedness emergency, to modify or suspend statutes, regulations, or other requirements that conflict with the protection of the public health, not just those that conflict with the efficient and expeditious execution of civil preparedness functions.

The act explicitly allows her to take such actions when she declares a public health emergency, but it appears that she may do so only if she has declared a civil preparedness emergency. By law, the governor may already, during a civil preparedness emergency, take steps that are reasonably necessary to protect the health of state residents and may

modify and suspend laws for certain occurrences, which may include situations affecting public health. Consequently, the legal effect of the new provision is unclear.

**EFFECTIVE DATE: October 1, 2010**

**Public Act 10-75 (House Bill 5435)**

**An Act Concerning the Recommendations of the Majority Leaders' Job Growth Roundtable**

*(Signed by Governor 5/6/2010)*

This act authorizes programs and policies for establishing or expanding businesses and creating jobs. It authorizes up to \$5 million in bonds for developing new business concepts (pre-seed financing). It also authorizes credits for investing in technology-based start-up businesses (angel investment tax credits) and expanding businesses, including those using green technologies (**insurance reinvestment tax credits**).

The act also authorizes funding and technical assistance for established businesses. It taps up to \$15 million in bonds from an existing authorization to provide loans and lines of credit for small businesses, provides technical assistance for all businesses seeking foreign markets for their goods and services, and authorizes financial incentives and technical assistance for businesses developing alternative energy technologies. It authorizes up to \$500,000 in bonds to fund the technical assistance. It creates a council to continuously assess the state's strategic business clusters and recommend how to address their needs.

The act also addresses workforce needs. It authorizes tax credits for businesses hiring new employees, including those with disabilities. It provides loan reimbursements and grants to Connecticut students seeking jobs in alternative energy technology and other related fields funded by transferring \$3 million from the quasi-public Connecticut Health and Educational Facilities Authority to the General Fund. The act authorizes up to \$1 million in bonds for programs to train unemployed people and up to \$1.5 million bonds for the existing Mortgage Crisis Job Training Program.

Besides authorizing new policies and programs for developing businesses and creating jobs, the act addresses government operations. It establishes a task force to boost government efficiency and eliminate waste and requires the Office of Fiscal Analysis to inform the legislature about the resources needed to determine how bills affect the economy's capacity to create and retain jobs.

Although the act authorizes several new tax credits, it sunsets those for (1) donating computers to public and private schools, (2) constructing new facilities housing financial institutions, and (3) paying Small Business Administration guaranty fees. It repeals these credits for income years beginning on or after January 1, 2014.

**Only insurance related provisions are outlined below.**

§ 14 — NEW INSURANCE REINVESTMENT FUND PROGRAM

*Leveraging Mechanism*

Just as the act uses tax credits to leverage private capital for start-up technology-based businesses, it also uses them to leverage private capital for established businesses. But it does so through a different mechanism. Instead of using CII to match investors and businesses, the act uses privately operated, state-certified investment funds to identify and market investment opportunities to business investors. The funds must be certified by DECD and meet performance standards.

The act models this mechanism on the existing Insurance Reinvestment Tax Credit Program, whose phase-out the act accelerates. The mechanism consists of (1) state-certified business investment funds, (2) businesses eligible to receive the funds' investments, and (3) business taxpayers that invest in the funds, for which they receive tax credits and returns on their investments.

The existing mechanism offers insurance premium, corporation business, and personal income tax credits to taxpayers that invest in insurance businesses through a state-certified fund. The taxpayers may claim the credits or transfer them to other investors. Either way, a portion of the credits may be claimed only over 10 years according to a statutory schedule. And those holding the credit may claim it only if the insurance business receiving the investment (1) developed a new facility, (2) occupies it over the 10-year period, and (3) employs at least 25% of its workforce in new jobs. The taxpayers must forfeit or repay the credits if the business fails to meet specific performance standards.

The new program has the same elements, but matches different investors and businesses. Because the act's tax credits apply only to the insurance premium tax, only insurance companies can invest in a state-certified fund and claim the credits. But the fund can invest in any Connecticut-based business, not just insurance companies, as under the existing program. The fund's insurance company investors qualify for credits if the fund invests in a business that:

1. employs fewer than 250 people when it received the investment;
2. netted no more than \$10 million in the previous year; and
3. conducts its principal operations in Connecticut, that is, at least 80% of its workers live here or 80% of its payroll goes to Connecticut residents (i. e., "Connecticut-based business").

The investors may carry forward unused portions of the credits, but cannot transfer them to other taxpayers.

While the existing program imposes performance standards on insurance companies receiving the investments, the new program imposes them on the investment fund. If a fund fails to meet the standards, investors risk forfeiting unclaimed credits. The act

imposes a \$40 million annual cap and a \$200 million aggregate cap on the amount of credits investors can claim under the new program.

### *Eligible Funds*

The act uses insurance premium tax credits to leverage private investments in Connecticut-based businesses. But insurers can access the credits only through state-certified “insurance reinvestment funds.” A fund qualifies for certification if it is a Connecticut partnership, corporation, trust, or limited liability company. It can be organized on a for-profit or nonprofit basis, but must be managed by at least two principals or people each of whom has at least four years of experience managing venture capital or private equity funds with at least \$50 million invested by people unaffiliated with the fund's manager.

The fund must obtain capital from other investors besides the insurance companies. It meets this requirement under the act if the equity from other investors comprises at least 5% of the capital invested by the insurers. The fund must be closed to additional investments and investors after it applies to the DECD commissioner for certification as an insurance reinvestment fund.

The fund must operate independently of its insurance company investors. The investors cannot control the fund, which would happen under the act if each company invests over \$40 million and can vote over half of the fund's equity interest. But they can take interim control if the fund breaches any payment obligation or contractual agreement affecting their ability to claim credits.

### *Eligible Investors and Investments*

As noted above, only taxpayers liable for insurance premium taxes qualify for the act's credits. A taxpayer qualifies for them only if it invests cash in an approved insurance reinvestment fund (i. e. , credit-eligible capital). The cash investment must fully pay for an equity interest in the fund or an eligible debt instrument, at par or at a premium, the fund issued.

A fund's debt instrument cannot:

1. mature less than five years after it is issued;
2. repay the debt faster than paying the principal in equal installments over five years; or
3. base interest, distribution, or other payments on the fund's profitability or investment success.

The company's ability to claim the credits depends on how the fund invests the company's dollars. The fund may invest these dollars only in eligible, Connecticut-based businesses. And, it may invest no more than 15% of the credit-eligible capital in one business without the commissioner's prior approval. The fund may invest this capital in bank deposits, certificates of deposit, or other fixed income securities. (Presumably, a fund would do so until it is ready to invest the capital in an eligible business. The act does not specify how the fund must account for the interest income these investments earn. )

### *Fund Certification*

Insurance companies qualify for credits only if they invested in a certified insurance reinvestment fund. To be certified, the fund must submit an application to DECD that:

1. indicates the amount of capital the fund will raise,
2. includes an affidavit from each investor committing investments to the fund,
3. includes a nonrefundable \$7,500 application fee,
4. contains evidence that the fund qualifies as an insurance reinvestment fund,
5. commits the fund to invest at least 25% of the credit-eligible capital in “green technology businesses,” and
6. commits the fund to invest at least 3% of the credit-eligible capital in pre-seed investments within three years after the fund was fully capitalized by insurance companies seeking credits.

The act specifies criteria for determining green technology businesses and requirements for making pre-seed investments. Under the act, a green technology business is one in which at least 25% of the jobs use or develop “green technology,” which the act does not define. These jobs may include those corresponding to green technology occupational codes devised by DECD and the Labor Department. The act also requires funds to make their pre-seed investments in consultation with CII's pre-seed financing program, which the act requires CII to establish (see §§ 10-11, above).

The application must also include a plan describing how the fund intends to invest the credit-eligible capital. The plan must:

1. estimate the share of credit-eligible capital the fund plans to invest by third, fifth, seventh and ninth years following the date on which it was fully capitalized by the credit-eligible capital;
2. identify the types of businesses targeted for investment and their respective share of the taxpayers' investment dollars;
3. estimate the share of credit-eligible capital going to businesses engaged in research and development or manufacturing, processing, or assembling technology-based products;
4. specify the number of jobs the fund expects to create or retain after the fund has invested all of the credit-eligible capital; and
5. show that the credit-eligible capital will generate tax revenue that equals or exceeds the credits' value (“revenue estimate”).

The fund may prepare the revenue estimate unless the commissioner requires a third party to do so.

As discussed below, the fund must comply with its investment plan or risk decertification, which could jeopardize its investors' unclaimed credits. But it can, with the commissioner's approval, change its plan because of unavoidable or reasonably unexpected changes, including economic changes; technological advances; high employment; and opportunities for revenue growth. The commissioner cannot unreasonably withhold approval. The DECD commissioner must begin accepting applications by July 1, 2010.

### *Insurance Premium Tax Credits*

The credits under the new component apply only to the insurance premium tax and equal 100% of an insurance company's investment in a fund. The company must claim the credits over 10 years, beginning in the fourth year after it invested in the fund. It can claim up to 10% of the credit per year in years four through seven, inclusive, and 20% per year in the last three years. As under the existing program, the company may carry unused credits forward for up to five years.

Companies may claim the credits under the same rules that apply under the existing program. These address how companies submitting a combined return may claim the credits. Lastly, companies claiming credits under the act cannot claim the other credits the law allows for same investment.

**EFFECTIVE DATE: July 1, 2010**

### § 14 — CHANGES TO EXISTING INSURANCE REINVESTMENT ACT PROGRAM

The act pushes up the deadline for allocating credits under the existing program and limits investors' ability to claim allocated ones. As noted above, the program provides business and personal income tax credits for investing in an insurance business. Investors may obtain these credits only through a DECD-registered insurance reinvestment fund. Further, they may claim only a specified portion of the credit total over 10 years and may do so only if the business develops a new facility; creates new jobs; and, during the 10-year period, continues to occupy the facility and retain those jobs. The business must annually certify to DECD that it meets these requirements.

Under prior law, DECD's authority to allocate credits expired on July 1, 2015. The act pushes up the expiration date to June 30, 2010 by prohibiting DECD from issuing new eligibility certificates after that date. Presumably, DECD may continue issuing certificates of continued eligibility to businesses that received their initial certificates before that date.

The act temporarily lifts the ban on allocating credits to funds formed after July 1, 2000 until June 30, 2010, the date on which DECD's authority to issue eligibility certificates expires. But it also ties an investor's ability to claim the credits to the fund's investment rate. In doing so, the act implicitly distinguishes between established funds that have received DECD's certificates of continued eligibility from newly formed ones that have not. Investors accessing credits through established funds may claim them only if the fund invested at least \$1 million by July 1, 2011.

Newly formed funds must also meet this investment threshold and prove that they did so. A fund must provide the proof by June 30, 2011; otherwise, the commissioner must revoke its eligibility certificate. The proof may include canceled checks, wire transfers, investment agreements, or other documentation that satisfies the commissioner.

The act tightens the eligibility criteria an insurance business must meet to qualify for credit-eligible investments. It specifies that Connecticut residents must hold the new jobs the business creates and retains. Under prior law, a business met the job requirement if it employed at least 25% of its workforce in new jobs, which by law must be one that did

not exist in the business when it applied for its initial certification. The jobs must be held by new employees, excluding those the business reassigned from another facility.

Lastly, the act specifies that investors who received credits before January 1, 2010 may carry them forward as the law allows. This provision applies to investors and taxpayers to whom they transferred the credits.

**EFFECTIVE DATE: July 1, 2010.**

**Public Act 10-107 (Senate Bill 176)**  
**An Act Concerning the Film Tax Credit**  
*(Signed by Governor 6/7/2010)*

This act modifies the criteria for accessing the corporation business and insurance premium tax credits for producing films and developing infrastructure in Connecticut.

A company producing film or digital media qualifies for credits based on the money and time it spends here. By law, the company must spend at least \$100,000 producing the film or media in Connecticut. The act retains this threshold but narrows the range of eligible expenses by excluding the money spent in Connecticut on developing the idea for the film or media and limiting compensation to base salaries and wages.

The law also requires the company to spend a certain amount of time or money in Connecticut on specific production tasks. Under prior law, the company had to conduct at least 50% of its principal photography days or incur at least 50% of the post-production costs in the state. The act reduces the minimum share of principal photography days in Connecticut to 25%. It also makes it easier for the company to qualify based on postproduction costs. Under the act, the company qualifies if it incurs at least 50% or \$1 million of those costs here.

Lastly, the act tightens the criteria for determining eligible production and infrastructure costs. It also makes a conforming technical change.

**EFFECTIVE DATE: July 1, 2010 and applicable to income years beginning on or after January 1, 2010.**

**Public Act 10-135 (House Bill 5436)**  
**An Act Concerning Brownfield Remediation Liability**  
*(Signed by Governor 6/8/2010)*

This act expands the scope of several brownfield clean-up programs, establishes a working group to study brownfield issues, and makes a technical correction (§ 4).

The act qualifies municipal and nonprofit development agencies for directors' and officers' liability and general liability insurance under an existing brownfield clean-up program. And it allows the Department of Economic and Community Development (DECD) commissioner to use the funds for an established brownfield program for two newer brownfield programs opened to municipalities and private developers.

The act allows municipalities to (1) fix the assessment on contaminated property before the owner begins to remediate it and (2) to forgive back taxes on a contaminated property if a developer proposes to remediate it under a state-approved plan.

The act sets narrow conditions under which a regulated activity must be permitted on municipally owned sites undergoing remediation in aquifer protection areas.

Lastly, the act establishes an 11-member working group to examine brownfield issues and requires it to report its findings and recommendations to the Commerce Committee by January 15, 2011. It requires the governor and legislative leaders to appoint the members and designates three state officials as ex-officio members.

**EFFECTIVE DATE: July 1, 2010, except for the provisions establishing the working group, which are effective upon passage; the provisions concerning the Urban Site Remediation Fund, which are effective October 1, 2010; and the provisions for fixing property tax assessments, which are effective July 1, 2010 and applicable to assessment years beginning on or after October 1, 2010.**

#### PROGRAM EXPANSIONS

##### *§§ 1 & 5 — Brownfield Clean-up Programs*

The act expands the range of activities that qualify for funds under the Urban Sites Remediation Program and the Special Contaminated Property Remediation and Insurance Fund. It allows the Department of Environmental Protection (DEP) commissioner to use the former to reimburse municipal and nonprofit development agencies for directors' and officers' liability insurance and general liability insurance. Under prior law, she could use the program only to acquire, assess, and remediate contaminated sites acquired by DECD or a regional economic development agency.

Municipal economic development agencies and those formed specifically to plan and implement redevelopment and municipal development projects qualify for reimbursement. Nonprofit organizations qualify if they were formed to promote a municipality's economic development and receive funds or in-kind services in part from the municipality, its economic development or redevelopment agencies, or a nonstock corporation or limited liability company the municipality established or controls.

The act also allows the DECD commissioner to tap the Special Contaminated Property Remediation and Insurance Fund for brownfield projects approved under the existing Remedial Action and Redevelopment Municipal Grant Program and the Targeted Brownfield Development Loan Program. The former provides grants to municipal and nonprofit agencies for assessing and remediating contaminated property. The latter

provides up to \$2 million in financing to municipal, nonprofit, and for-profit developers for investigating and remediating brownfields.

**Public Act 10-142 (House Bill 5207)**

**An Act Concerning Criminal Background Checks for Prospective State Employees  
(VETOED; OVERRIDDEN)**

This act prohibits certain state employers from asking about a prospective employee's past convictions until the person is deemed otherwise qualified for the position. The prohibition does not apply if a statute specifically disqualifies someone from a position due to a prior conviction.

The applicable employers are the state; the executive and judicial branches, including any of their boards, departments, commissions, institutions, agencies, or units; boards of trustees of state-owned or -supported colleges, universities, or their branches; public and quasi-public state corporations; authorities established by law; and anyone designated by such employers to act in their interest with employees. The act does not cover the state Board of Labor Relations, Board of Mediation and Arbitration, or, apparently, the Legislative Branch. This means these employers may ask a prospective employee about prior convictions. However, the law, unchanged by the act, prohibits these and other state agencies from denying a person employment solely because of a prior conviction.

**EFFECTIVE DATE: October 1, 2010**

**Public Act 10-155 (House Bill 5163)**

**An Act Requiring the Establishment of a Searchable Database for State Expenditures**

*(Signed by Governor 6/5/2010)*

By July 1, 2011, this act requires the Office of Fiscal Analysis (OFA) to establish and maintain searchable databases of state expenditures, including state grants and contracts. The databases must be posted on OFA's Internet website. To enable OFA to establish and maintain the databases, the act requires budgeted agencies to submit, in a timely manner, information that OFA requests. It states explicitly that its provisions do not require state agencies to (1) create unavailable financial or management data or a nonexistent information technology system or (2) disclose consumer, client, patient, or student information that is protected from disclosure under other laws.

Starting by November 1, 2010, OFA must report quarterly to the Appropriations Committee on the databases, including any recommendations for improving or expanding their operation or capacity. The Auditors of Public Accounts must review the procedures and security used to develop the databases and report any findings or recommendations to the Appropriations Committee.

**EFFECTIVE DATE: Upon passage**

**Public Act 10-165 (House Bill 5197)**  
**An Act Implementing the Recommendations of the Program Review and**  
**Investigations Committee Concerning the Postponement of Program Termination**  
**Dates in the Sunset Law**  
*(Signed by Governor 6/8/2010)*

This act delays for one year the review of all agencies and programs subject to termination under the sunset law. Under the sunset law, 78 licensing, regulatory, and other state agencies and programs terminate on set dates unless the General Assembly reestablishes them after the Legislative Program Review and Investigations Committee conducts a performance audit of each. The committee must review the public need for each entity according to established criteria and report to the legislature its recommendations for the entity's abolition, reestablishment, modification, or consolidation. The act delays the termination dates as follows:

<i>Prior Termination Date</i>	<i>New Termination Date</i>
July 1, 2012	July 1, 2013
July 1, 2013	July 1, 2014
July 1, 2014	July 1, 2015
July 1, 2015	July 1, 2016
July 1, 2016	July 1, 2017

**EFFECTIVE DATE: Upon passage**

**Public Act 10-169 (House Bill 5202)**  
**An Act Concerning Telecommuting Options for State Employees**  
*(Signed by Governor 6/7/2010)*

Prior law allowed the Department of Administrative Services (DAS) commissioner to develop and implement guidelines authorizing state employee telecommuting and work-at-home programs. The act instead requires the commissioner to develop and implement these guidelines, within available appropriations, to (1) increase worker efficiency and productivity, (2) benefit the environment, and (3) reduce traffic congestion.

Under the act, a telecommuting or work-at-home assignment must meet the programs' guidelines. It eliminates the requirement that an assignment must be determined to be cost effective.

It specifies that the guidelines and the decision on whether a position is appropriate for telecommuting are not subject to collective bargaining. By law, the guidelines must be developed and implemented in cooperation with state employee unions.

**EFFECTIVE DATE: July 1, 2010**

#### AUTHORIZATION AND DURATION

The act specifies that agency heads and the executive director of the Office of Legislative Management, or her designee, may authorize employees to participate in the programs. It eliminates the requirement that the DAS commissioner also approve an employee's participation.

The act eliminates the six-month limit on telecommuting assignments. Instead it states that the assignment must be temporary and may be terminated as required by agency operating needs.

Each agency must provide the DAS with a copy of each telecommuting or work-at-home program agreement authorized for an employee.

#### REPORTING TO THE LEGISLATURE

The act requires the DAS commissioner to provide her annual report on employee use of the program to the Government Administration and Elections Committee. The law already required the report to be submitted to the Labor and Public Employees Committee.