



**CONNECTICUT  
INSURANCE  
DEPARTMENT  
LEGISLATIVE  
SUMMARY**

**2011**

# Connecticut Insurance Department 2011 Legislative Summary

## Forward

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

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## **Acts Proposed by the Insurance Department**

The Connecticut Insurance Department proposed several legislative initiatives at the beginning of the 2011 legislative session some of which were incorporated into one large healthcare reform bill, House Bill 6308, which has become Public Act 11-58. Specifically, proposals related to Third-Party Administrations (formerly HB 6307), certain Patient Protection and Affordable Care Act provisions, and External Appeals (formerly SB 1158) became part of PA 11-58. These Department initiatives are summarized below. Other relevant parts of PA 11-58 are summarized in another section of this report titled Acts of Direct Interest to the Insurance Department-Life and Health.

In addition, legislation related to captive insurers was proposed and enacted during the Special Session on Economic Growth, which was held in October of 2011 and is also summarized within this section.

### **Public Act 11-58 (House Bill 6308) An Act Concerning Healthcare Reform (Became law 7/1/11, not signed by the Governor)**

#### **THIRD PARTY-ADMINISTRATORS**

Require the Insurance Department to license and regulate third-party administrators (TPA) (Sections 20 through 36).

#### **DEFINITIONS (Section 20)**

With certain exceptions, a third-party administrator (TPA) is one who directly or indirectly (1) underwrites; (2) collects charges or premiums; or (3) adjusts or settles claims on Connecticut residents with respect to life, annuity, or health coverage offered or provided by an insurer.

The act excludes from the definition of TPA:

1. an employer administering its employee benefit plan or that of an affiliated employer under common management and control;
2. a union administering a benefit plan on its members' behalf;
3. an insurer licensed in Connecticut or acting as an authorized insurer with respect to insurance lawfully issued to cover a Connecticut resident, and its sales representatives;
4. an insurance producer licensed to sell life, annuity, or health coverage in Connecticut, who just sells insurance;
5. a creditor acting on its debtors' behalf with respect to insurance covering a debt between the creditor and its debtors;
6. a trust and its trustees and agents acting pursuant to a trust established under federal law that restricts financial transactions with labor organizations;
7. a tax-exempt trust and its trustees, or a custodian and the custodian's agents acting pursuant to an account meeting federal requirements for custodial accounts and contracts treated as qualified trusts;

8. a mortgage lender, credit union, or financial institution subject to supervision or examination by federal or state banking authorities, when collecting or remitting premiums to licensed insurance producers, limited lines producers, or authorized insurers in connection with loan payments;
9. a credit card company advancing or collecting insurance premiums or charges from its credit card holders who have authorized collection;
10. an attorney adjusting or settling claims in the normal course of his or her practice or employment who does not collect charges or premiums in connection with life, annuity, or health coverage;
11. an insurance adjuster whose activities are limited to adjusting claims;
12. an insurance producer licensed in Connecticut and acting as a managing general agent whose activities are limited to those specified in law;
13. a business entity affiliated with an insurer licensed in Connecticut that undertakes activities as a TPA only for the direct and assumed insurance business of the affiliated insurer;
14. a consortium of state-funded federally qualified health centers that provide services only to recipients of programs administered by the Department of Social Services;
15. a pharmacy benefits manager registered with the insurance commissioner;
16. an entity providing administrative services to the Health Reinsurance Association; and
17. a nonprofit association or one of its direct subsidiaries that provides access to insurance as part of the benefits or services the association or subsidiary makes available to its members.

#### *Underwriting*

The act defines “underwriting” as (1) accepting applications from employers or individuals for coverage in accordance with the written rules of the insurer or self-funded plan and (2) the overall planning and coordination of a benefits program.

#### *Adjuster*

The act defines “adjuster” as an independent or contracted person who investigates or settles claims, excluding an insurer's employee who investigates or settles claims incurred under insurance contracts the insurer or an affiliated insurer writes.

#### *Insurer*

The act defines an “insurer” as a person or people doing insurance business, including a captive insurer, a licensed insurance company, a medical or hospital service corporation, an HMO, or a consumer dental plan, that provides employee welfare benefits on a self-funded basis. It excludes a fraternal benefit society.

**EFFECTIVE DATE: October 1, 2011**

#### TPA LICENSE REQUIREMENT (Section 21)

The act prohibits a person (including an entity) from offering to act as a TPA in Connecticut unless licensed or exempt from licensure. This prohibition does not apply to a TPA's employee to the extent that his or her activities are under the TPA's supervision and control. But, the act does not exempt a TPA's employees from the licensing

requirements regarding public adjusters, casualty adjusters, motor vehicle physical damage appraisers, certified insurance consultants, surplus lines brokers, or any other insurance-related occupation for which the commissioner deems a license necessary. (See TPA Licensing Process below for more details.) Certain entities that are exempt from TPA licensure but that perform similar services must register annually with the insurance commissioner.

#### *License Exemption*

A licensed insurer that underwrites, collects premiums or charges, or adjusts or settles claims, except for its policyholders, subscribers, and certificate holders, is exempt from the act's requirements. These insurers must (1) be subject to the Connecticut Unfair Insurance Practices Act, (2) respond to all complaint inquiries received from the Insurance Department within 10 days of receiving them, and (3) obtain a customer's prior written consent for advertising mentioning the customer.

#### *ERISA Plans*

The act specifies that it does not authorize the commissioner to regulate a self-insured plan subject to the federal Employee Retirement Income Security Act (ERISA). The commissioner is authorized to regulate activities an insurer undertakes for such plans that do not relate to the benefit plan and that comport with his authority under ERISA to regulate the business of insurance.

#### *Written Agreement*

Under the act, a TPA must have a written agreement with the insurer (hereafter, insurer includes another person using the TPA's services). The agreement must be kept as part of the official records of both the TPA and the insurer until five years after the contract ends. The agreement must contain all of the following provisions, except those that do not apply to the functions the TPA performs:

1. a statement of activities that the TPA must perform on the insurer's behalf;
2. the lines, classes, or types of insurance the TPA may administer;
3. a requirement that the TPA render an accounting, on an agreed frequency, detailing all transactions it performs pertaining to the insurer's underwritten businesses;
4. the procedures for any withdrawals to be made, including remittance, deposits, transfers to and deposits in a claims-paying account, payment to a group policyholder, payment to the TPA for commissions, fees, or charges, and remittance of return premiums;
5. procedures and requirements for required disclosures; and
6. termination and dispute resolution procedures.

#### *Termination and Disputes Regarding Lawful Obligations*

A TPA or insurer may, with written notice, terminate the written agreement for cause as provided in the agreement. The insurer may also suspend the TPA's underwriting authority while the termination is pending. In a dispute between the TPA and the insurer regarding the fulfillment of a lawful obligation with respect to a policy or plan subject to the written agreement, the insurer must fulfill the obligation.

**EFFECTIVE DATE: October 1, 2011**

### PAYMENTS TO INSURERS (Section 22)

The act specifies that insurance premiums or charges paid to a TPA by an insured party or on its behalf are deemed to have been received by the insurer. "Return premium" or claim payments the insurer forwards to the TPA are not deemed to have been paid to the insured party or claimant until the insured party or claimant receives them. The act specifies that it does not limit an insurer's rights to sue the TPA for its failure to pay the insurer, insured parties, or claimants.

**EFFECTIVE DATE: October 1, 2011**

### BOOKS AND RECORDS OF TRANSACTIONS PERFORMED ON PAYOR'S BEHALF (Section 23)

The act requires a TPA to maintain and make available to an insurer with which it contracts complete books and records of all transactions performed on the insurer's behalf. The TPA must maintain the books and records (1) in accordance with prudent standards of insurance recordkeeping and (2) for at least five years after they were created.

Under the act, the insurer owns any records the TPA generates pertaining to the insurer. But the TPA retains the right to access the books and records to fulfill its contractual obligations to insured parties, claimants, and the insurer.

If a written agreement is terminated, the TPA may, by a separate written agreement with the insurer, transfer all books and records to a new TPA. The new TPA must acknowledge to the insurer, in writing, that it is responsible for retaining the books and records of the prior TPA.

#### *Insurers Affiliated with Certain Business Entities*

An insurer that is affiliated with a business entity (i. e. , a for-profit or nonprofit corporation, a limited liability company, or similar form of business organization) is responsible for the acts of that business entity to the extent of the entity's activities as a TPA for such insurer. Upon the commissioner's request, the insurer is responsible for furnishing the books and records of all transactions performed on behalf of the insurer to the commissioner.

#### *Access to Books and Records*

The commissioner must have access to examine, audit, and inspect books and records maintained by a TPA. Any documents, materials, or other information in the possession or control of the commissioner obtained from a TPA, insurer, insurance producer, or employee or agent acting on their behalf, in an investigation, examination or audit are (1) confidential by law and privileged, (2) not subject to disclosure under the Freedom of Information Act, (3) not subject to subpoena, and (4) not subject to discovery or admissible in evidence in any private civil action. However, the commissioner may use these documents, materials, or other information in any regulatory or legal action brought as a part of the commissioner's official duties. Neither the commissioner nor anyone who receives documents, materials, or other information may testify or be required to testify in any private civil action concerning them.

The commissioner may share and receive documents, materials, or other information deemed confidential and privileged with other state, federal, and international regulatory

agencies; the National Association of Insurance Commissioners (NAIC) or its affiliates or subsidiaries; and state, federal, and international law enforcement authorities, provided the recipient of such documents, materials, or other information agrees to maintain their confidentiality and privileged status. He may also enter into agreements governing the sharing and use of information.

Disclosures to the commissioner do not waive any applicable privilege or claim of confidentiality. The act does not prohibit the commissioner from releasing final, adjudicated actions, including terminated TPA licenses, to a database or other clearinghouse service maintained by the NAIC or its affiliates or subsidiaries.

**EFFECTIVE DATE: October 1, 2011**

#### ADVERTISING BY A TPA (Section 24)

The act requires a TPA who advertises on an insurer's behalf to use only advertising that the insurer approves, beforehand, in writing. A TPA that mentions any customer in its advertising must obtain the customer's prior written consent.

**EFFECTIVE DATE: October 1, 2011**

#### ADMINISTRATION OF BENEFITS (Section 25)

Each insurer is responsible for determining the benefits, premium rates, underwriting criteria, and claims payment procedures for the lines, classes, or types of insurance the TPA is authorized to administer, and for securing reinsurance. The insurer must provide to the TPA, in writing, administration procedures for benefits, premium rates, underwriting criteria, and claims payment. Each insurer is responsible for the competent administration of its benefit and service programs.

If the TPA administers benefits for more than 100 certificate holders on behalf of an insurer, the insurer must conduct a review of the TPA's operations at least semiannually. At least one such review must be an on-site audit.

**EFFECTIVE DATE: October 1, 2011**

#### FIDUCIARY CAPACITY (Section 26)

The act requires the TPA to hold in a fiduciary capacity (1) all insurance charges and premiums it collects on behalf of or for an insurer and (2) return premiums received from an insurer. The act requires TPAs to (1) immediately return funds to the person entitled to them or (2) deposit them promptly in a fiduciary account the TPA establishes and maintains in a federally insured financial institution. The TPA must provide a periodic accounting to the insurer, detailing all transactions it performed pertaining to the insurer's business.

#### *Record Maintenance*

The act requires the TPA to keep clear records of deposits and withdrawals and copies of all records of any fiduciary account it maintains or controls on an insurer's behalf and, at an insurer's request, give the insurer copies of the deposit and withdrawal records.

### *Paying Claims*

The act prohibits a TPA from paying any claim by withdrawing funds from a fiduciary account in which premiums or charges are deposited. Withdrawals from such an account must be made as provided in the TPA's written agreement. The act requires that all claims

a TPA pays from funds collected on behalf of or for an insurer must be paid only by drafts or checks of, and as authorized by, the insurer.

**EFFECTIVE DATE: October 1, 2011**

### COMPENSATION (Section 27)

The act prohibits a TPA from entering into an agreement or understanding with an insurer that makes or has the effect of making the TPA's commissions, fees, or charges contingent upon savings achieved by the adjustment, settlement, or payment of losses covered by the insurer's obligations. This prohibition does not prevent a TPA from receiving performance-based compensation for providing auditing services. It also does not prevent a TPA's compensation from being based on premiums or charges collected or the number of claims paid or processed.

**EFFECTIVE DATE: October 1, 2011**

### NOTICE AND DISCLOSURE (Section 28)

The act requires that when a TPA's services are used, the TPA must give each insured a benefits identification card that discloses the TPA's identity and its relationship with the policyholder and insurer.

The act requires a TPA, when it collects premiums, charges, or fees, to inform the insured person of the reasons for each. Additional charges are prohibited to the extent the insurer has paid for the services.

The act requires the TPA to disclose to the insurer all charges, fees, and commissions that it receives for services it provides the insurer, including any fees or commissions paid by insurers providing reinsurance or stop loss coverage.

**EFFECTIVE DATE: October 1, 2011**

### PROMPTLY DELIVER WRITTEN COMMUNICATIONS (Section 29)

The act requires a TPA to promptly deliver written communications on the insurer's behalf. The TPA must deliver, promptly after receiving instructions from the insurer, any policies, certificates, booklets, termination notices, or other written communications the insurer delivers to the TPA for delivery to insured parties or covered individuals.

**EFFECTIVE DATE: October 1, 2011**

### TPA LICENSING PROCESS (Section 30)

#### *Surety Bond Requirement*

The act requires a TPA applicant to execute a surety bond in an amount to be determined by the commissioner, but (1) sufficient to protect insurers or others using the TPA's services and (2) not less than \$500,000. A TPA must maintain the bond as a condition for license renewal.

The commissioner may waive the bond requirement if the TPA applicant submits audited annual financial statements for the two most recent fiscal years that prove the TPA has a

positive net worth. An audited annual financial statement prepared on a consolidated basis must include a columnar consolidating or combining worksheet that must be filed with the report and include (1) amounts shown on the consolidated audited financial report, (2) amounts for each entity stated separately, and (3) explanations of consolidating and eliminating entries. A TPA who has submitted such statements in lieu of executing a surety bond and who is renewing its license must submit the most recent audited annual financial statement.

#### *Application*

The act requires a TPA applying for a license to (1) submit a completed application to the commissioner (by using the current version of the “NAIC's Uniform Application for Third Party Administrators”) and (2) pay the required fee (see § 36).

The application must include or be accompanied by the following information and documents:

1. the applicant's basic organizational documents, including any articles of incorporation or association; partnership, trust, or shareholder agreement; trade name certificate; and other applicable documents;
2. the bylaws, rules, regulations, or similar documents regulating the applicant's internal affairs;
3. a NAIC biographical affidavit for the people responsible for the applicant's affairs, including (a) all members of the board of directors, board of trustees, executive committee, or other governing board or committee; (b) the principal officers in the case of a corporation, or the partners or members in the case of a partnership, association, or limited liability company; (c) any shareholder or member directly or indirectly holding 10% or more of its stock, securities, or interest; and (d) any other person who exercises control or influence over the applicant's affairs;
4. evidence of the required surety bond;
5. a statement describing the business plan, including (a) information on staffing levels and activities proposed in Connecticut and nationwide and (b) details of the applicant's ability to provide a sufficient number of experienced and qualified personnel for claims processing, recordkeeping, and underwriting; and
6. other pertinent information the commissioner may require.

#### *Access to Records*

The act requires a TPA applying for a license to provide for the commissioner's inspection copies of all contracts with insurers or others using the TPA's services. The TPA must produce its accounts, records, and files for examination and make its officers available to give information concerning its affairs, as often as the commissioner reasonably requires.

#### *License Refusal*

The commissioner may refuse to issue a license if he determines that:

1. the TPA or any individual responsible for conducting its affairs is not competent, trustworthy, financially responsible, or of good personal and business reputation;
2. the TPA has had an insurance or a TPA certificate of authority or license denied or revoked for cause by any jurisdiction; or

3. any of the grounds relating to the act's enforcement requirements exist with respect to the TPA.

*Miscellaneous Requirements*

A license issued to a TPA is in force until September 30<sup>th</sup> in each year, unless revoked or suspended before that date. The commissioner, at his discretion, may renew a TPA license upon receiving payment of the required fee without having the TPA reapply.

A TPA licensed or applying for a license must immediately notify the commissioner of any material change in its ownership, control, or other fact or circumstance affecting its qualification for a license.

In addition to the surety bond described above, a licensed TPA or applicant that administers or will administer self-insured government or church plans must execute and maintain a surety bond, for use by the commissioner and the insurance regulatory authority of any other state in which the TPA is authorized to conduct business, to cover people who have remitted premiums, insurance charges, or other money to the TPA in the course of the TPA's business. The bond must be equal to the greater of (1) \$100,000 or (2) 10% of the aggregate total amount of self-funded coverage under government or church plans handled in Connecticut and all additional states in which the TPA is authorized to conduct business.

**EFFECTIVE DATE: October 1, 2011**

REGISTRATION REQUIREMENT (Section 31)

A person who is not required to be licensed as a TPA but who directly or indirectly underwrites, collects charges or premiums from, or adjusts or settles claims for Connecticut residents in connection with a self-insured life, annuity, or health coverage plan must annually register with the commissioner by October 1 on a form he designates. This does not apply if the self-insured plan is a government or church plan.

**EFFECTIVE DATE: October 1, 2011**

ANNUAL REPORT (Section 32)

The act requires each licensed TPA to file an annual report with the commissioner for the preceding calendar year by July 1 each year or within a time extension the commissioner grants for good cause. The annual report must be in the form and contain the information the commissioner prescribes, including evidence that the required surety bonds, as applicable, remain in force. The information contained in the report must be verified by at least two of the TPA's officers.

The annual report must include the complete names and addresses of all insurers with which the TPA had agreements during the preceding fiscal year. The TPA must pay the required filing fee when it files the annual report.

The act requires the commissioner to review each TPA's most recently filed annual report by September 1. After the review, the commissioner must issue a certification to the TPA, or update the NAIC's electronic database, indicating (1) that it is currently licensed and in good standing or (2) any deficiencies found in the annual report or financial statements.

**EFFECTIVE DATE: October 1, 2011**

### ENFORCEMENT (Section 33)

The act requires the commissioner to suspend or revoke a TPA's license or issue a cease and desist order if the TPA does not have a license, after notice and hearing, if he finds that the TPA:

1. is financially unsound;
2. is using methods or business practices that render its further business in Connecticut hazardous or injurious to insured persons or the public; or
3. failed to pay any judgment rendered against it in Connecticut within 60 days after the judgment became final.

The act authorizes the commissioner to suspend or revoke a TPA's license or issue a cease and desist order if the TPA does not have a license, after notice and hearing, if he finds that the TPA:

1. violated any (a) lawful rule or order of the commissioner or (b) provision of applicable Connecticut insurance laws;
2. refused to be examined or produce its accounts, records, and files, or any individual responsible for its affairs for examination;
3. without just cause, (a) refused to pay proper claims or perform its contractual services or (b) caused covered individuals to accept less than the amount due or employ attorneys or bring suit against the TPA to secure full payment or settlement of the claims;
4. failed at any time to meet any license qualification that would have been grounds for the commissioner to refuse to issue a license;
5. had a person responsible for its affairs who has been convicted of or pled guilty or no contest to a felony, without regard to whether adjudication was withheld;
6. is under license suspension or revocation in another state; or
7. failed to file an annual report in a timely manner.

The commissioner may, without advance notice and before a hearing, issue an order immediately suspending a TPA's license, or a cease and desist order if the TPA does not have a license, if he finds that:

1. the TPA is insolvent or impaired;
2. another state has started a proceeding for receivership, conservatorship, rehabilitation, or other delinquency proceeding regarding the TPA; or
3. the TPA's financial condition or business practices pose an imminent threat to the public health, safety, or welfare of Connecticut residents.

When the commissioner issues an order suspending a license or a cease and desist order, he must notify the TPA that it may request a hearing within 10 business days of receiving the order. If a hearing is requested, the commissioner must schedule it within 10 business days after receiving the request. If a hearing is not requested and the commissioner does not choose to hold one, the order remains in effect until the commissioner modifies or vacates it.

**EFFECTIVE DATE: October 1, 2011**

### ADOPTION OF REGULATIONS (Section 34)

The act authorizes the insurance commissioner to adopt regulations relating to TPAs.

**EFFECTIVE DATE: October 1, 2011**

### MARKET CONDUCT EXAMINATION (Section 35)

The act authorizes the commissioner, as often as he deems it expedient, to examine the market conduct of any TPA doing business in Connecticut. He already has this authority with respect to insurance companies, HMOs, and fraternal benefit societies.

**EFFECTIVE DATE: October 1, 2011**

### FEES (Section 36)

The act establishes the following fees that the insurance commissioner must collect from a TPA:

1. \$500 for each license issued,
2. \$350 for each license renewal, and
3. \$100 for each annual report filed.

**EFFECTIVE DATE: October 1, 2011**

### **PATIENT PROTECTION AND AFFORDABLE CARE ACT COMPLIANCE (PPACA)**

The act requires insurers to comply with PPACA. It authorizes the insurance commissioner to adopt regulations. (Section 53)

It specifies that state law provisions concerning PPACA are not to be construed to supersede any state law that provides greater protection to an insured, unless it prevents the application of PPACA.

**EFFECTIVE DATE: Upon passage**

### **UTILIZATION REVIEW, GRIEVANCE, AND EXTERNAL APPEAL**

Revises the health insurance utilization review, grievance, and external appeal statutes to comply with the Patient Protection and Affordable Care Act (PPACA) (Sections 54 through 89).

### DEFINITIONS (Section 54)

The act defines numerous terms regarding utilization review, grievance, and external review processes used throughout §§ 55 to 66.

The act expands the definition of “adverse determination.” Under prior law, “adverse determination” meant a decision by a managed care organization, health insurer, or utilization review company to deny, reduce, or end payment for a covered admission, service, procedure, or extension of stay because it did not meet that entity's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness. Under the act, “adverse determination” includes a health carrier's denial, reduction, termination, or failure to pay for a requested benefit because the benefit (1) does not meet the carrier's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness or (2) is determined to be experimental or investigational. It includes any adverse prospective, concurrent, or retrospective review determinations and coverage rescissions.

Under prior law, “utilization review” meant a prospective or concurrent assessment of the necessity and appropriateness of the allocation of health care resources given to or proposed for a person. The act (1) redefines the term to mean formal techniques used to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings and (2) expands it to include retrospective reviews in addition to prospective or concurrent reviews.

**EFFECTIVE DATE: July 1, 2011**

#### GENERAL REQUIREMENTS (Section 55)

Prior law gave the insurance commissioner the authority to regulate utilization review companies. It contained licensing requirements, minimum standards, and appeal and enforcement procedures. The act makes changes to the utilization review process to conform it to federal PPACA requirements.

#### *Health Carriers*

The act applies to (1) health carriers offering a health benefit plan and performing utilization review, including prospective, concurrent, or retrospective review benefit determinations, and (2) utilization review companies or a health carrier's designee that performs utilization review. A “health carrier” is an entity that (1) is subject to Connecticut's insurance laws and regulations or the insurance commissioner's jurisdiction and (2) contracts to provide, deliver, arrange for, pay, or reimburse the costs of health care services. It includes insurers, health care centers (i. e. , HMOs), managed care organizations, hospital or medical service corporations, or any other entity that provides health insurance, health benefits, or health care services.

A health carrier must (1) monitor all utilization review activities carried out by or on behalf of it and (2) ensure that any utilization review company or other entity it contracts with to perform utilization review complies with the act and any related regulations. A health carrier must ensure that appropriate personnel have operational responsibility for the activities of the health carrier's utilization review program.

#### *Utilization Review Program*

A health carrier that requires utilization review must implement a program and develop a written document that describes all utilization review activities and procedures for (1) filing benefit requests, (2) notifying covered persons of utilization review and benefit determinations, and (3) reviewing adverse determinations (e. g. , benefit denials) and grievances. The document must include:

1. procedures to evaluate the medical necessity, appropriateness, health care setting, level of care, or effectiveness of health care services;
2. data sources and clinical review criteria used in making determinations;
3. procedures to ensure consistent application of clinical review criteria and compatible determinations;
4. data collection processes and analytical methods used to assess utilization of health care services;
5. provisions to ensure the confidentiality of clinical, proprietary, and protected health information;

6. the health carrier's organizational mechanism, such as a utilization review or quality assurance committee, that periodically assesses the health carrier's utilization review program and reports to the health carrier's governing body; and

7. the health carrier's staff position responsible for managing the utilization review program.

A health carrier must include in the insurance policy, coverage certificate, or handbook provided to those covered a description of the procedures for utilization review and benefit determinations, grievances, and external reviews in a format the insurance commissioner prescribes. The description must include the following statements:

1. the subscriber or other covered person may file a request for an external review of an initial or final adverse determination with the commissioner when the determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness (the disclosure document must include the commissioner's contact information);

2. the covered person must authorize the release of related medical records when filing a request for an external review (i. e. , a review conducted by an independent third party);

3. the rights and responsibilities of covered persons with respect to utilization review and benefit determinations, grievances, and external reviews; and

4. a covered person has the right to contact the commissioner or the healthcare advocate at any time for assistance (the disclosure document must include the contact information for both offices).

A health carrier must also:

1. inform people it covers, at initial enrollment and annually thereafter, of its grievance procedures;

2. inform a covered person and his or her health care professional (i. e. , a licensed health care practitioner) of the grievance procedures whenever the health carrier denies a benefit requested by the health care professional;

3. include a summary of its utilization review and benefit determination procedures in materials intended for prospective covered persons;

4. print on its membership or identification cards a toll-free telephone number for utilization review and benefit determinations;

5. maintain records of all benefit requests, claims, and notices related to utilization review and benefit determinations for at least six years and make the records available upon request to the commissioner and federal oversight agencies; and

6. maintain records of all grievances received in accordance with the act and make the records available upon request to (a) covered persons, if the records can be disclosed under law, (b) the commissioner, and (c) federal oversight agencies.

### *Annual Reporting*

By March first annually, a health carrier must file with the commissioner a (1) summary report of its utilization review program activities in the prior calendar year and (2) report that includes for each type of health benefit plan offered:

1. a certificate of compliance certifying that the utilization review program complies with all applicable state and federal laws concerning confidentiality and reporting requirements,

2. the number of lives covered,

3. the total number of grievances received,
4. the number of grievances resolved at each level and their resolution,
5. the number of grievances known to have been appealed to the commissioner,
6. the number of grievances referred to alternative dispute resolution procedures or resulting in litigation, and
7. actions being taken to correct any identified problems.

The act requires the commissioner to adopt regulations to establish the form and content of the annual reports.

**EFFECTIVE DATE: July 1, 2011**

#### OVERSIGHT OF UTILIZATION REVIEW PROGRAM (Section 56)

The act requires a health carrier to contract with (1) health care professionals to administer its utilization review program and oversee utilization review determinations and (2) clinical peers to evaluate the clinical appropriateness of an adverse determination. A “clinical peer” is a licensed physician or other health care professional in the same or similar specialty that typically manages the medical condition, procedure, or treatment under review.

Each utilization review program must use documented clinical review criteria based on sound clinical evidence and evaluated periodically by the health carrier's organizational mechanism to assure the program's effectiveness. A health carrier may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors the commissioner approves. Each health carrier must make its clinical review criteria available upon request to authorized government agencies.

A health carrier must:

1. have procedures in place to ensure that the health care professionals administering the utilization review program are applying the clinical review criteria consistently;
2. have data systems that support utilization review program activities and generate management reports to enable the health carrier to monitor and manage health care services effectively;
3. provide covered persons and participating providers access to its utilization review staff through a toll-free telephone number or electronically;
4. coordinate the utilization review program with other medical management activity conducted by the health carrier, such as quality assurance, credentialing, contracting with health care professionals, data reporting, grievance procedures, member satisfaction assessment, and risk management; and
5. routinely assess the effectiveness and efficiency of its utilization review program.

#### *Delegation*

If a health carrier delegates any utilization review activities to a utilization review company, the health carrier must maintain adequate oversight, including (1) a written description of the utilization review company's activities and responsibilities, (2) evidence of the health carrier's formal approval of the company, and (3) a process by which the health carrier evaluates the company's performance.

### *Necessary Information Only*

When conducting utilization review, the health carrier must (1) collect only the information needed, including pertinent clinical information, to make the utilization review or benefit determination and (2) ensure that the review is conducted in a way that ensures the independence and impartiality of the individuals involved in making the utilization review or benefit determination.

### *Personnel Decisions*

A health carrier cannot make decisions regarding the hiring, compensation, termination, promotion, or other similar matters of individuals involved in making utilization review or benefit determinations based on the likelihood that the individuals will support benefit denials.

**EFFECTIVE DATE: July 1, 2011**

## UTILIZATION REVIEW AND BENEFIT DETERMINATIONS (Section 57)

### *Written Procedures*

The act requires a health carrier to maintain written procedures for (1) utilization review and benefit determinations, (2) expedited utilization review and benefit determinations relating to prospective and concurrent urgent care requests, and (3) notifying covered persons of its determinations. (Hereafter, “covered persons” includes their authorized representatives.)

### *Prudent Layperson*

When determining if a benefit request is an urgent care request, the health carrier must apply the judgment of a prudent layperson with an average knowledge of health and medicine. However, a request must be considered urgent if a health care professional with knowledge of the covered person's medical condition determines that it is.

### *Urgent Care Review Request*

Unless the covered person has failed to provide information necessary for the health carrier to make a determination, the carrier must determine whether or not to certify the benefit and notify the covered person within 72 hours after receiving the request. For a concurrent urgent care review request, the carrier must make a determination within 24 hours before the current course of treatment expires.

If the covered person failed to provide information necessary for the health carrier to make a determination, the carrier must notify the person as soon as possible but within 24 hours after receiving the request. In all cases, the carrier must provide the person at least 48 hours to submit the information.

A health carrier must notify the covered person of its determination as soon as possible but within 48 hours after the earlier of (1) the date the person provides the information or (2) the date the information was to have been submitted.

### *Non-Urgent Care Review Request*

For a prospective or concurrent non-urgent review request, a health carrier must determine whether or not to certify the benefit and notify the covered person within 15

days after receiving the request. For a retrospective review request, the health carrier must make a determination within 30 days after receiving the request.

The health carrier may extend either time period once for up to 15 days if it (1) determines an extension is necessary due to circumstances beyond its control and (2) notifies the covered person before the initial time period ends of the circumstances requiring the extension and the date by which the health carrier expects to make a determination.

If the extension is needed because the covered person failed to submit information necessary to reach a determination, the health carrier must (1) specifically describe in the extension notice the information necessary to complete the request and (2) give the covered person at least 45 days to provide this information. If the covered person fails to submit the information before the end of the extension period, the health carrier may deny the requested benefit.

#### *Procedural Failure*

Whenever a health carrier receives a review request from a covered person that fails to meet the carrier's filing procedures, the carrier must notify the covered person of the failure. The carrier must send the notice within five days after receiving the request for a non-urgent request or within 24 hours for an urgent care request. The health carrier may provide the notice orally if it provides written confirmation within five days after providing the oral notice.

#### *Notice of Adverse Determination*

A health carrier must provide promptly to a covered person an adverse determination notice, either in writing or electronically. It must include, in a way the covered person can understand:

1. sufficient information to identify the benefit request or claim involved, including the date of service, health care professional, and claim amount;
2. the specific reason for the adverse determination and a description of the health carrier's standard used in deciding to issue the denial;
3. reference to the specific health benefit plan provisions on which the determination is based;
4. a description of any additional material or information the covered person needs to complete the benefit request or claim, including an explanation of why the material or information is necessary;
5. a description of the health carrier's internal grievance process, including expedited review procedures, applicable time limits, and contact information;
6. a statement that the person may, pursuant to the requirements of the carrier's internal grievance process, (a) submit written material relating to the request and (b) receive, free of charge upon request, reasonable access to and copies of all information relevant to his or her request;
7. if the adverse determination is based on a health carrier's internal rule, guideline, protocol or other similar criterion, (a) the specific rule, guideline, protocol, or other similar criterion or (b) a statement that one of these was relied upon to make the adverse determination and that a copy will be provided to the covered person free of charge on request, with instructions for requesting a copy;

8. if the adverse determination is based on medical necessity or an experimental or investigational treatment or similar exclusion or limit, the written statement of that scientific or clinical rationale and (a) an explanation of the rationale that applies the terms of the health benefit plan to the covered person's medical circumstances or (b) a statement that an explanation will be provided to the covered person free of charge on request and instructions for requesting a copy; and
9. a statement explaining the covered person's right to (a) contact the insurance commissioner or Office of Healthcare Advocate at any time for assistance and contact information or (b) file, upon completion of the health carrier's internal grievance process, a civil suit in a court of competent jurisdiction.

#### *Rescission*

If the adverse determination is a rescission (i. e. , retroactively cancelling insurance after a policyholder becomes sick or is injured), the health carrier must include with the advance notice of the rescission application a written statement that includes:

1. clear identification of the alleged fraudulent act, practice, or omission or intentional misrepresentation of material fact;
2. an explanation of why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;
3. a disclosure that the covered person may immediately file a grievance with the health carrier to request a review of the adverse determination to rescind coverage;
4. a description of the health carrier's grievance procedures, including any applicable time limits; and
5. the date the advance notice of the proposed rescission ends and the date to which the coverage will be retroactively rescinded.

#### *Strict Adherence Required*

Whenever a health carrier fails to strictly adhere to the utilization review and benefit determination requirements, the covered person is deemed to have exhausted the health carrier's internal grievance process and may file for an external review, regardless of whether the health carrier asserts substantial compliance or *de minimis* error.

A covered person who has exhausted the internal grievance process of a health carrier may, in addition to filing a request for an external review, pursue any available remedies under state or federal law on the basis that the health carrier failed to provide a reasonable internal grievance process that would yield a decision on the claim's merits.

**EFFECTIVE DATE: July 1, 2011**

#### INTERNAL GRIEVANCE PROCESS (Section 58)

Prior law required managed care organizations and health insurers to have an internal grievance procedure for enrollees to seek a review of grievances arising from the entity's actions or inaction. The act expands upon existing law to conform it to the federal PPACA.

#### *Written Procedures Required*

A health carrier must establish and maintain written procedures for (1) reviewing grievances of adverse determinations that were based on medical necessity, (2) the

expedited review of grievances of adverse determinations of urgent care requests, and (3) notifying covered persons of its adverse determinations.

#### *Filing Required*

A health carrier must file with the commissioner a copy of the procedures, including all forms used to process requests and any subsequent material modifications to the procedures.

A health carrier also must file annually with the commissioner, as part of its annual report described above, a certificate of compliance stating that it has established and maintains grievance procedures that fully comply with the act's provisions for each of its health benefit plans.

#### *Grievance of Adverse Determination Based on Medical Necessity*

A covered person may file a grievance of an adverse determination that was based, in whole or in part, on medical necessity with the health carrier within 180 days after the covered person receives the adverse determination notice. For prospective or concurrent urgent care requests, a person can request an expedited review orally or in writing. The health carrier must ensure that an adverse determination review is conducted in a manner that ensures the independence and impartiality of the individuals involved in making the review decision.

#### *Clinical Peer*

If the adverse determination involves utilization review, the health carrier must designate one or more appropriate clinical peers to review the determination. The clinical peers cannot have been involved in the initial adverse determination.

The individuals conducting a grievance review must consider all comments, documents, records, and other information the covered person submits relevant to his or her benefit request that is the subject of the adverse determination under review, regardless of whether such information was submitted or considered in making the initial adverse determination.

#### *New or Additional Evidence*

Before issuing a decision, the health carrier must provide free of charge to the covered person any new or additional evidence relied upon or scientific or clinical rationale used in connection with the grievance. The carrier must provide the evidence and rationale sufficiently in advance of the carrier's determination date to allow the person a reasonable opportunity to respond before then.

#### *Transmitting Information and Decision*

For an expedited review, the health carrier must transmit all information, including its decision, to the covered person by telephone, fax, electronically, or other expeditious method.

### *Treatment During Concurrent Review*

For an expedited review of a grievance involving an adverse determination of a concurrent review urgent care request, treatment must be continued without liability to the covered person until the person has been notified of the review decision.

### *Decision Time Period*

The health carrier must notify the covered person in writing or electronically of its decision within specified time periods. A time period begins on the date the health carrier receives the grievance, regardless of whether all of the information necessary to make the decision accompanies the filing. (Under prior law, grievances had to be resolved within 60 days.)

For a grievance of an adverse determination involving an expedited review request, the health carrier must decide and notify the covered person of the decision within 72 hours after receiving it.

For a grievance of an adverse determination involving a prospective or concurrent review request, the health carrier must decide and notify the covered person of the decision within 30 days after receiving it.

For a grievance of an adverse determination involving a retrospective review request, the health carrier must decide and notify the covered person of the decision within 60 days after receiving it.

### *Decision Notice*

The health carrier's notice must include, in a way the covered person can understand:

1. the titles and qualifying credentials of the individuals participating in the review process;
2. enough information to identify the claim involved, including the date of service, health care professional, and claim amount;
3. a statement of the reviewers' understanding of the grievance;
4. the reviewers' decision in clear terms and the health benefit plan contract basis or scientific or clinical rationale for the decision in sufficient detail for the covered person to respond further to the health carrier's position;
5. reference to the evidence or documentation used as the basis for the decision;
6. if applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner"; and
7. a statement disclosing the covered person's right to contact the commissioner or the healthcare advocate at any time and the contact information.

If a decision upholds the adverse determination, the notice must contain:

1. the specific reason for the final adverse determination, including the denial code and its corresponding meaning and a description of the health carrier's standard used in reaching the denial;
2. a reference to the specific health benefit plan provisions on which the decision is based;
3. a statement that the covered person may receive from the health carrier, free of charge and on request, reasonable access to and copies of all relevant documents, records, and other information;

4. if the final adverse determination is based on a health carrier's internal rule, guideline, protocol or other similar criterion, (a) the specific rule, guideline, protocol, or other similar criterion or (b) a statement that one of these was relied upon to make the final adverse determination and that a copy of it will be provided to the covered person free of charge on request, with instructions for requesting such copy;
5. if the final adverse determination is based on medical necessity or an experimental or investigational treatment or similar exclusion or limit, a written statement of the scientific or clinical rationale for the final adverse determination and (a) an explanation of the rationale used to make the determination that applies the terms of the health benefit plan to the covered person's medical circumstances or (b) a statement that an explanation will be provided to the covered person free of charge on request, with instructions for requesting a copy of the explanation; and
6. the procedures for obtaining an external review.

#### *Strict Adherence Required*

Whenever a health carrier fails to strictly adhere to the grievance requirements, the covered person is deemed to have exhausted the carrier's internal grievance process and may file an external review, regardless of whether the carrier asserts substantial compliance or *de minimis* error.

A covered person who has exhausted the health carrier's internal grievance process may, in addition to filing an external review, pursue any available remedies under state or federal law on the basis that the health carrier failed to provide a reasonable internal grievance process that would yield a decision on the merits of the claim.

#### *Grievance of Adverse Determination Not Based on Medical Necessity*

A covered person may file a grievance of an adverse determination that was not based on medical necessity with the health carrier within 180 days after the covered person receives the adverse determination notice.

#### *Written Procedures*

A health carrier must establish and maintain written procedures for (1) reviewing grievances of adverse determinations that were not based on medical necessity and (2) notifying covered persons of its adverse determinations.

#### *Notice Required*

A health carrier must, within three business days of receiving a grievance, notify a covered person that he or she may submit written material for consideration by the individuals designated by the health carrier to conduct the grievance review.

Upon receiving a grievance, a health carrier must designate individuals to conduct a grievance review. The health carrier cannot designate the same individuals who denied the claim or handled the matter that is the subject of the grievance.

A health carrier must give the covered person the name, address, and telephone number of the person or organizational unit designated to coordinate the review on the health carrier's behalf.

### *Decision Time Period*

A health carrier must notify the covered person in writing of its decision within 20 business days after receiving the grievance.

If the health carrier is unable to meet the 20-day deadline due to circumstances beyond its control, it may extend the time period for up to 10 business days, provided that before the initial 20-day period ends, the health carrier provides written notice to the covered person of the extension and the reasons for the delay.

### *Decision Notice*

The written decision notice must include:

1. the titles and qualifying credentials of the individuals participating in the review process,
2. a statement of the individuals' understanding of the grievance,
3. the individuals' decision in clear terms and the health benefit plan contract basis for the decision in sufficient detail for the covered person to respond further to the health carrier's position, and
4. reference to the evidence or documentation used as the basis for the decision.

**EFFECTIVE DATE: July 1, 2011**

### EXTERNAL REVIEW PROCESS (Section 60)

Under prior law, enrollees who exhausted the internal grievance process could appeal a claim denial to the insurance commissioner, who would assign the review to an independent third party. The act expands upon existing law to conform it to the federal PPACA.

### *Written Request*

A covered person may file with the commissioner a written request for a standard or expedited external review of an adverse determination or a final adverse determination. The commissioner may prescribe the form and content of such review requests.

### *Filing Fee*

By law, a covered person requesting an external review has to pay a \$25 filing fee. But the act specifies that no one will have to pay more than \$75 in any calendar year. By law, if the commissioner finds the covered person is indigent or unable to pay the fee, the commissioner must waive the fee. All fees are deposited in the Insurance Fund. The commissioner must refund any paid filing fee if the adverse determination or final adverse determination that is the subject of the standard or expedited external review is reversed or revised.

### *Health Carrier Pays for the Review*

The health carrier that issued the adverse determination or final adverse determination that is the subject of the external review request must pay the independent review organization for the cost of conducting the external review, whether the review is standard or expedited.

### *Decision is Binding*

An external review decision, whether standard or expedited, is binding on the health carrier or self-insured government plan and the covered person, except to the extent they have other remedies under federal or state law.

A covered person cannot file a subsequent request for a standard or expedited external review that involves the same adverse determination or final adverse determination for which he or she already received a standard or expedited external review decision.

### *Written Records Required*

Health carriers and independent review organizations must maintain written records of external reviews.

### *Exhaustion of Internal Grievance Process and Waiver*

A covered person cannot request a standard or expedited external review until he or she has exhausted the health carrier's internal grievance process. However, a covered person can request an external review before exhausting the internal grievance process if the health carrier agrees to waive the exhaustion requirement.

### *Written Disclosure of External Review*

When a health carrier sends a covered person an adverse determination notice or a final adverse determination, it must include a written disclosure of his or her right to request an external review. The written notice must include:

1. the following or substantially similar statement: “We have denied your request for benefit approval for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us by submitting a request for external review to the office of the Insurance Commissioner, if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested;”
2. for a notice related to an adverse determination, a statement informing the covered person that (a) if the person has a medical condition for which the time period for completing an expedited internal review of a grievance involving an adverse determination would seriously jeopardize his or her life or health or jeopardize his or her ability to regain maximum function, the covered person may file a request for an expedited external review and (b) the request for expedited external review may be filed at the same time the person files a request for an expedited internal review of a grievance involving an adverse determination, except that the independent review organization assigned to conduct the expedited external review determines whether the covered person must complete the expedited internal review of the grievance before it performs the expedited external review;
3. for a notice related to a final adverse determination, a statement informing the covered person that he or she may file for an expedited external review if (a) the covered person has a medical condition for which the time period for completion of an external review would seriously jeopardize his or her life or health or jeopardize his or her ability to regain maximum function or (b) the final adverse determination concerns (i) an admission, availability of care, continued stay, or health care service for which the

covered person received emergency services but has not been discharged from a facility or (ii) a denial of coverage based on a determination that the requested health care treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that the requested treatment would be significantly less effective if not promptly initiated;

4. a copy of the description of both the standard and expedited external review procedures, highlighting external review procedures that give the covered person the opportunity to submit additional information and including any forms used to process a standard or expedited external review; and

5. a medical records release authorization form approved by the commissioner that complies with federal regulations.

#### *Expedited External Review*

A covered person may file a request for an expedited external review of an adverse determination or a final adverse determination with the commissioner; an expedited external review is not available for a retrospective review request.

The covered person may file an expedited external review request when he or she receives:

1. an adverse determination, if the covered person has (a) a medical condition for which the time period for completing an expedited internal review of the adverse determination would seriously jeopardize his or her life or health or jeopardize his or her ability to regain maximum function or (b) been denied coverage on the basis that the service or treatment is experimental or investigational and the person's treating health care professional certifies in writing that the service or treatment would be significantly less effective if not promptly started, and the person filed a request for an expedited internal review of an adverse determination; or

2. a final adverse determination, if (a) the covered person has a medical condition for which the time period for completing a standard external review would seriously jeopardize his or her life or health or jeopardize his or her ability to regain maximum function, (b) the determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility, or (c) the coverage was denied on the basis that the service or treatment is experimental or investigational and the person's treating health care professional certifies in writing that the service or treatment would be significantly less effective if not started promptly.

The covered person is not required to file a standard external review request before or at the same time as filing an expedited external review request. If the expedited external review request is ineligible for review, the covered person can still file a standard external review request.

#### *External Review Process and Time Periods*

##### *Covered Person*

A covered person may file with the commissioner a written request for a standard or expedited external review of an adverse determination or a final adverse determination within 120 days of receiving notice of the determination. Under prior law, a person had 60 days to file an expedited review.

### *Commissioner*

Within one business day after receiving the request, the commissioner must send a copy of it to the health carrier whose determination is the subject of the request.

### *Health Carrier*

Within five business days after receiving a copy of a standard external review request or one calendar day after receiving a copy of an expedited external review request, the health carrier must complete a preliminary review to determine whether:

1. the individual was a covered person under the health benefit plan at the time the health care service was requested or provided;
2. the involved health care service is a covered service under the covered person's health benefit plan except for the health carrier's determination that it does not meet its requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;
3. the covered person has exhausted the health carrier's internal grievance process or filed an expedited external review request; and
4. the covered person has provided all the information and forms required to process a standard or expedited external review.

If the service or treatment is experimental or investigational, the health carrier must also determine whether:

1. the requested health care treatment that is the subject of the determination (a) is a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational and (b) is not explicitly excluded under the covered person's health benefit plan;
2. the covered person's treating health care professional has certified that (a) standard health care treatments have not been effective in improving the covered person's medical condition, (b) standard health care treatments are not medically appropriate for the person, or (c) there is no available standard health care treatment covered by the health carrier that is more beneficial than the requested health care treatment; and
3. the covered person's treating health care professional (a) has recommended a health care treatment that he or she certifies, in writing, is likely to be more beneficial to the covered person than any available standard health care treatments or (b) is a licensed, board certified, or board eligible health care professional qualified to practice in the area of medicine appropriate to treat the covered person's condition and has certified, in writing, that scientifically valid studies using accepted protocols demonstrate that the health care treatment the covered person requested is likely to be more beneficial than any available standard health care treatments.

### *Initial Determination Notice*

The health carrier must notify the commissioner and covered person in writing on whether the request is complete and eligible for external review within one business day after completing the preliminary review for a standard external review request or on the day the preliminary report is completed for an expedited external review request. The commissioner may specify the form for the health carrier's initial determination notice.

If the request is not complete, the health carrier's notice must specify the information needed to perfect the request. If the request is not eligible for standard or expedited external review, the notice must include the reasons for its ineligibility. The notice must include a statement informing the covered person that he or she can appeal an initial determination of ineligibility to the commissioner.

Regardless of a health carrier's initial determination that a request for a standard or expedited external review is ineligible for review, the commissioner may determine, pursuant to the terms of the covered person's health benefit plan, that the request is eligible and assign an independent review organization to conduct it.

#### *Assignment of Independent Review Organization*

Within one business day, for a standard external review request, or one calendar day, for an expedited external review request, of receiving notice that a request is eligible for review, the commissioner must (1) assign an independent review organization to conduct the review (randomly from among qualified organizations), (2) notify the health carrier of the organization's name, and (3) notify the covered person in writing of the request's eligibility and acceptance for review.

The written notice must include (1) a statement that the covered person may submit, within five business days after receiving the notice, additional information in writing to the organization for consideration and (2) where and how such additional information must be submitted. If additional information is submitted later than five business days after the covered person received the notice, the organization may, but is not be required to, accept and consider it.

#### *Health Carrier Must Provide Information*

Within five business days for a standard external review and one calendar day for an expedited external review after receiving the name of the assigned independent review organization, the health carrier or its designated utilization review company must provide the organization any information it considered in making the determination under review. If the carrier or utilization review company fails to timely provide the information, the organization (1) must not delay performing the review and (2) may terminate the review and make a decision to reverse the determination.

Within one business day after terminating the review and deciding to reverse the determination, the organization must notify the commissioner, health carrier, and covered person in writing.

#### *Independent Review Organization*

The organization must review all the information received from the covered person and health carrier. In reaching a decision, the organization is not bound by any decisions reached during the health carrier's utilization review process.

Upon receiving any information from the covered person, the organization has one business day to forward it to the health carrier.

#### *Health Carrier Reconsideration*

Upon receiving the covered person's information from the organization, the health carrier may reconsider the adverse determination that is the subject of the external review. The

organization must terminate the external review if the health carrier decides to reverse its determination.

Within one business day after making the decision to reverse its determination, the health carrier must notify the commissioner, organization, and covered person in writing.

#### *Other Information the Organization Must Consider*

In reaching its decision, the organization also must consider, to the extent they are available and appropriate, the following:

1. the covered person's medical records;
2. the attending health care professional's recommendation;
3. consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, or the treating health care professional;
4. the covered person's health benefit plan's coverage terms to ensure the organization's decision is not contrary to those terms;
5. the most appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards, or associations;
6. any applicable clinical review criteria the health carrier or its designee utilization review company developed and used; and
7. after considering the above items, the opinion of the organization's clinical peers who conducted the review.

#### *Decision Time Period*

After receiving a review assignment from the commissioner, the organization must notify the commissioner, health carrier, and covered person in writing of its decision to uphold, reverse, or revise the determination that is the subject of the review, within:

1. for standard external reviews, 45 days;
2. for standard external reviews involving an experimental or investigational treatment or service, 20 days;
3. for expedited external reviews, 72 hours; and
4. for expedited external reviews involving an experimental or investigational treatment or service, five days.

#### *Decision Notice*

The written notice must include:

1. the reason for the requested review;
2. the dates the organization received the assignment, performed the review, and made its decision;
3. the rationale and principal reasons for its decision, including the applicable evidence-based standards used as a basis for its decision; and
4. reference to the evidence or documentation, including any evidence-based standards, the organization considered in reaching its decision.

For a review involving an experimental or investigational treatment or service, the notice must also include:

1. the covered person's medical condition;

2. the indicators relevant to determining whether there is sufficient evidence to demonstrate that (a) the requested treatment is likely to be more beneficial to the covered person than any available standard treatments and (b) the adverse risks of the requested treatment would not be substantially increased over those of available standard treatments;
3. a description and analysis of any (a) medical or scientific evidence considered in reaching the opinion and (b) evidence-based standard; and
4. information on whether the clinical peer's rationale for the opinion is based on the other information a clinical peer must consider in developing an opinion.

#### *Health Carrier Action*

Upon receiving a decision notice from the organization that reverses the health carrier's determination, the health carrier must immediately approve the coverage that was the subject of the determination.

**EFFECTIVE DATE: July 1, 2011**

### RECORD RETENTION AND REPORTING REQUIREMENTS (Section 61)

#### *Grievance Records*

The act requires a health carrier to maintain written records documenting all grievances of adverse determinations it receives, including the notices and claims associated with the grievances, during a calendar year. It must maintain the records for at least six years from the date it provided a covered person an adverse determination notice.

A health carrier must make grievance records available upon request to covered persons if the records are subject to disclosure under law, the commissioner, and appropriate federal oversight agencies. It must maintain the records in a way that is reasonably clear and accessible to the commissioner.

For each grievance, the record must include at least the (1) reason for the grievance, (2) date the health carrier received the grievance, (3) date of each review or review meeting of the grievance, (4) resolution and resolution date at each grievance level, and (5) covered person's name.

#### *Annual Report*

A health carrier must submit an annual grievance report to the commissioner by March 1.

#### *External Review Records*

A health carrier must maintain written records, in the aggregate, by state where the covered person requesting an external review resides and by each type of health benefit plan the health carrier offers, on all external review requests received during a calendar year. It must retain the records for at least six years after receiving the external review request.

The carrier must, upon request, report to the commissioner on the external reviews in a format the commissioner prescribes. The report must include, in the aggregate by state where the covered person requesting the external review resides and by each type of health benefit plan (1) the total number of external review requests, whether standard or

expedited; (2) the number of requests determined eligible for an external review, whether standard or expedited; and (3) any other information the commissioner requests.

**EFFECTIVE DATE: July 1, 2011**

REGULATIONS (Sections 62 and 66)

The act requires the commissioner to adopt implementing regulations.

**EFFECTIVE DATE: July 1, 2011**

UTILIZATION REVIEW LICENSE FEE (Section 63)

By law, a utilization review company must be licensed by the commissioner to do business here. Under prior law, the annual license fee was \$2,500. The act increases this fee to \$3,000.

The act authorizes the commissioner to use the license fees to contract with the UConn School of Medicine to provide medical consultations needed to carry out the commissioner's responsibilities under Title 38a with respect to consumer and market conduct matters. By law, the commissioner may already use the license fees to implement the captive insurance company requirements in CGS §§ 38a-91aa to 38a-91qq.

**EFFECTIVE DATE: July 1, 2011**

INDEPENDENT REVIEW ORGANIZATIONS (Section 65 and 66)

Prior law established minimum requirements for independent review entities. The act expands upon these requirements to conform to federal PPACA requirements.

Under the act, the commissioner must (1) approve independent review organizations as eligible to conduct standard and expedited external reviews, (2) develop an application form for initial approvals and reapprovals of organizations, and (3) maintain and periodically update a list of approved organizations.

An organization seeking to conduct external reviews must apply for approval or reapproval, as applicable, to the commissioner, and include all information necessary for the commissioner to determine if the organization satisfies the minimum qualifications.

An approval or reapproval is effective for two years, unless the commissioner determines before its expiration that the organization no longer satisfies the minimum qualifications. When the commissioner determines that an organization has lost its accreditation or no longer satisfies the minimum requirements, the commissioner must remove the organization from the list of approved organizations.

*Minimum Qualifications*

As under prior law, to be eligible for the commissioner's approval, an organization must maintain written policies and procedures that govern all aspects of both the standard and expedited external review processes. The act requires it to maintain at a minimum:

1. a toll-free telephone number to receive information 24 hours a day, seven days a week, related to standard and expedited external reviews and that is capable of accepting, recording, or providing appropriate instruction to callers during other-than-normal business hours and
2. a quality assurance mechanism that ensures:
  - (a) that reviews are conducted within the specified time frames and required notices are provided in a timely manner,

- (b) the selection of qualified and impartial clinical peers to conduct reviews on the organization's behalf and the suitable matching of peers to specific cases,
- (c) the organization employs or contracts with an adequate number of clinical peers,
- (d) the confidentiality of medical and treatment records and clinical review criteria, and
- (e) that any person employed by or under contract with the organization adheres to the act's requirements.

The organization must also:

1. agree to maintain and provide to the commissioner the information required by the act;
2. not own or control, be a subsidiary of, be owned or controlled in any way by, or exercise control with a health benefit plan, a national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care professionals; and
3. assign as a clinical peer a health care professional who meets the following minimum qualifications:
  - (a) is an expert in the treatment of the covered person's medical condition that is the subject of the external review;
  - (b) is knowledgeable about the recommended treatment through recent or current actual clinical experience treating patients with the same or similar medical condition;
  - (c) holds a nonrestricted license in the United States and, for physicians, a current certification by a recognized American medical specialty board in the area appropriate to the subject of the external review; and
  - (d) has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency, or unit or regulatory body that raise a substantial question as to his or her physical, mental, or professional competence or moral character.

#### *National Accreditation*

An organization is presumed to meet the minimum qualifications if it is accredited by a nationally recognized private accrediting entity that has independent review organization accreditation standards that the commissioner determines are equivalent to or exceed the minimum qualifications. The commissioner must initially and periodically review the independent review organization accreditation standards of the nationally recognized private accrediting entity to determine whether the standards are, and continue to be, equivalent to or exceed the required minimum qualifications. The commissioner may accept a review conducted by the National Association of Insurance Commissioners (NAIC) for this purpose.

Upon request, a nationally recognized private accrediting entity must provide its current independent review organization accreditation standards to the commissioner or NAIC. The commissioner may exclude any private accrediting entity that is not reviewed by NAIC.

#### *Conflict of Interests*

The commissioner cannot assign an organization, and no organization can assign a clinical peer, to conduct a standard or expedited external review if the organization or clinical peer has a material professional, familial, or financial conflict of interest with:

1. the health carrier or any of its officers, directors, or managers;

2. the covered person or his or her authorized representative;
3. the health care provider, the provider's medical group, or independent practice association recommending the treatment;
4. the facility at which the treatment would be provided; or
5. the developer or manufacturer of the drug, device, procedure, or other therapy being recommended.

To determine whether an organization or clinical peer has a material professional, familial, or financial conflict of interest, the commissioner must consider situations in which the organization or a clinical peer may have an apparent relationship or connection with a person described above, but the characteristics of the relationship or connection are not material.

#### *Organization Must Be Unbiased*

An organization must be unbiased and must, in addition to any other written procedures the act requires, establish and maintain written procedures to ensure that it is unbiased.

#### *Limited Immunity*

An organization; clinical peer; or an organization's employee, agent, or contractor is not liable for damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

#### *Record Retention and Reporting Requirements*

An organization assigned to conduct a standard or expedited external review must maintain written records, in the aggregate by state where the covered person requesting the review resides and by health carrier, on all reviews it conducted during a calendar year. It must retain the records for at least six years after receiving the review assignment. Upon request, the organization must report to the commissioner in a format he prescribes. The report must include, in the aggregate by state where the covered person requesting the external review resides and by health carrier:

1. the total number of requests for review, whether standard or expedited;
2. the number of requests resolved and, of those resolved, the numbers upholding and reversing the adverse determination;
3. the average time for resolution;
4. a summary of the coverage or case types for which an external review was sought;
5. the number of external reviews that were terminated as a result of a health carrier's reconsideration of its determination after receiving additional information from the covered person; and
6. any other information the commissioner requires.

**EFFECTIVE DATE: July 1, 2011**

#### POLICY RESCISSIONS (SECTION 69)

The PPACA limits policy rescissions (e. g., retrospective policy cancellations) to instances of fraud and intentional material misrepresentation.

Connecticut law requires an insurer or HMO to obtain the commissioner's approval for a policy rescission, cancellation, or limitation. The act requires the commissioner to

approve a request for rescission or limitation when the insured or the insured's representative submitted fraudulent (rather than false) information on an insurance application, intentionally (rather than knowingly) misrepresented material information on it, or intentionally (rather than knowingly) omitted material information from it. He must approve a cancellation in accordance with federal law, which requires prior notification to the insured.

**EFFECTIVE DATE: July 1, 2011**

TEMPORARY PROCEDURE FOR FORM FILINGS (Section 88)

By law, health carriers must file their policy and certificate forms for the commissioner's approval before use. The act allows health carriers to temporarily follow a "file and use" method of filing for policy forms or endorsements relating to utilization review, grievance process, or external review procedures for use on or after July 1, 2011. Health carriers must file their policy forms or endorsements with a certification to the commissioner that the policy forms meet the requirements of law. The carriers can then use the forms until and unless the commissioner disapproves their use. Health carriers can use this temporary procedure until June 30, 2012.

**EFFECTIVE DATE: July 1, 2011**

TECHNICAL AND CONFORMING CHANGES; REPEALED SECTIONS (Sections 63, 64, 67, 68, 70 to 87 and 89)

These sections make technical and conforming changes, including repealing the existing utilization review, grievance, and external appeals process. But the act recodifies some of the repealed sections, including penalties for a utilization review company that violates the act's provisions.

**EFFECTIVE DATE: July 1, 2011**

**Public Act 11-45 (Senate Bill 28; House Bill 6629, Sections 16 and 17)  
An Act Concerning Surety Bail Bond Agents and Professional Bondsmen  
(Signed by the Governor 6/13/2011)**

This act makes changes to, and adds new, requirements for surety bail bond agents and professional bail bondsmen. (A surety bail bond agent, through a contract with an insurer, sells bail bonds in criminal cases and is regulated by the insurance commissioner. A professional bondsman puts up personal assets as bond security and is regulated by the public safety commissioner.)

The act expands surety bail bond licensing and appointment requirements. It establishes (1) bail bond solicitation, record retention, and reporting standards and (2) premium financing, build-up funds, and collateral security requirements and restrictions. It requires agents to certify under oath to the insurance commissioner that they charged the bond premium rates the commissioner approved (i.e., did not discount or increase them). It authorizes the insurance commissioner to (1) suspend or revoke a bail bond agent's license, impose a penalty of up to \$5,000, or both for violating the act and (2) adopt implementing regulations.

The act also (1) restricts bail bond solicitation by professional bondsmen in the same way as it does for surety bail bond agents, (2) establishes collateral security requirements for them, and (3) allows the public safety commissioner to examine professional bondsmen records and adopt implementing regulations. The act also makes technical and conforming changes.

**EFFECTIVE DATE: October 1, 2011**

SURETY BAIL BOND AGENT LICENSING, APPOINTMENTS, AND EXAMINATION OF BOOKS (Sections 1 and 15)

By law, it is illegal to act as a surety bail bond agent unless licensed by the insurance commissioner and appointed by an insurer. To obtain a license, a person must file a completed application, pay an application fee, pass a written examination, and submit to a criminal history records check. By law, anyone acting as an agent without a license is guilty of a class D felony (see Table on Penalties).

The act prohibits a person engaged in law enforcement or vested with police powers from being licensed as a surety bail bond agent.

*Disqualifying Offense*

The act expands the list of convictions that disqualify a person from being licensed as an agent to include convictions for any misdemeanor involving dishonesty or misappropriation of money or property. The law already disqualifies a person if he or she was convicted of any felony or any of the following misdemeanors:

1. illegal drug possession;
2. criminally negligent homicide;
3. 3<sup>rd</sup>- degree assault;
4. 3<sup>rd</sup>-degree assault of an elderly, blind, disabled, pregnant, or mentally retarded person;
5. 2<sup>nd</sup>-degree threatening;
6. 1<sup>st</sup>-degree reckless endangerment;
7. 2<sup>nd</sup>-degree unlawful restraint;
8. 2<sup>nd</sup>-degree failure to appear;
9. 1<sup>st</sup>- or 2<sup>nd</sup>-degree rioting or inciting others to riot; or
10. 2<sup>nd</sup>-degree stalking.

The act requires an insurer, managing general agent, or agent to notify the commissioner in writing within five days of learning that an agent was arrested for, pleaded guilty or no contest to, or was found guilty of a disqualifying offense in Connecticut or a similar offense in another state, whether a court entered or withheld judgment.

The act defines “managing general agent” as a person an insurer appoints or employs to supervise the bail bond business that the insurer's appointed surety bail bond agents write in Connecticut.

*Appointments*

By law, an agent must have an insurer's notice of appointment on file with the commissioner to act on the insurer's behalf.

The act specifies that, by appointing an agent, an insurer is (1) certifying that, to the best of its knowledge and belief, the person is competent, financially responsible, and suitable to serve as the insurer's representative and (2) bound by the person's acts within the scope

of his or her actual or apparent authority as the agent. The act prohibits agents from representing that they have authority to act on an insurer's behalf until the insurer has appointed them.

By law, an appointment continues in force until the agent's license terminates or the insurer, its representative, or the agent files a termination notice. The act specifies that the appointment notice is filed with the insurance commissioner.

The act prohibits agents from acting, or attempting to act, on the insurer's behalf after their appointment is terminated. However, it permits an insurer that terminates an agent's appointment to authorize the agent to (1) take into custody a person who has absconded and for whom a bail bond was written before the appointment was terminated and (2) try to have forfeitures and judgments discharged.

#### *Examination of Books and Records; Examination Fee and Account*

The act permits the insurance commissioner to examine a surety bail bond agent's books and records as often he deems necessary to enforce the act. He already has this power with respect to license eligibility.

The act requires agents to pay the commissioner a \$450 fee by January 31 each year to cover the costs of these examinations. The commissioner must deposit the fees in a surety bail bond agent examination account, which the act creates as a separate, nonlapsing account in the Insurance Fund. The account must contain any money required to be deposited in it. The commissioner must use the money in the account for examinations. Any money remaining in the account at the end of each fiscal year must be transferred to the General Fund.

#### *Notification of Bankruptcy or Change in Address or Telephone Number*

The act requires an agent to give written notice to the commissioner within 30 days after (1) changing his or her name or residence address or (2) any bankruptcy proceeding by the agent or any administrative action or order against the agent in this or another state. (The notice must also include all supporting documentation. ) The act requires an agent to give written notice within 30 days of changing his or her business name, principal business address, or telephone number to the commissioner, appointing insurer, and managing general agent.

#### *License Fees*

The act sets the surety bail bond agent licensing fees at (1) \$150 for filing an initial license application and (2) \$100 for issuing or renewing a license. Under prior law, the commissioner set these fees. The act requires license applicants to pay the fees before the commissioner issues the license. It specifies that a license expires on January 31 in even-numbered years.

#### NOTICE TO COURTS AND POLICE DEPARTMENTS (Section 2)

By law, the insurance commissioner must give all courts and police departments in Connecticut a list of licensed surety bail bond agents and notify them of any change in the agent's status. The act requires him to also (1) provide the agent's principal business address and telephone number and (2) notify them of a change in the agent's business name, principal business address, or telephone number.

### PREMIUM REQUIREMENTS (Section 3)

The act prohibits agents from executing a bail bond unless they charge the premium rate the insurance commissioner approved. It specifies that it does not prohibit or limit a premium financing arrangement that complies with its provisions (see § 4).

#### *Premium Certifications*

##### *Monthly*

The act requires agents, by the 10<sup>th</sup> of each month, to certify under oath to the commissioner, on a form he prescribes, that the premium for each surety bail bond executed during the prior month did not differ from the approved premium rate. If an agent files a false certification, the commissioner may, after notice and hearing, suspend or revoke the agent's license, impose a penalty of up to \$5,000, or both.

##### *Annual*

By January 31 each year, the act requires insurers to file a statement with the commissioner certifying the total amount of bail bonds executed and the total amount of premiums collected in the preceding calendar year.

#### *Audit Requirement*

The act requires insurers transacting surety bail bond business in Connecticut to audit their appointed agents twice per year to ensure each is charging the approved premium rate. The audits must cover (1) January 1 to June 30 and (2) July 1 to December 31. Within 45 days after each audit period ends, insurers must notify the commissioner of any agent who failed to charge the approved premium rate. The notice must include the:

1. agent's name;
2. case docket number, if assigned;
3. total bond amount;
4. date the bond was executed,
5. insurer's National Association of Insurance Commissioners identification code; and
6. date the premium was due.

### PREMIUM FINANCING ARRANGEMENTS (Section 4)

The act allows surety bail bond agents to enter into premium financing arrangements with a principal or indemnitor where the agents extend credit. If they enter into such arrangements, they must require the principal on the bond or any indemnitor to (1) make a minimum down payment of 35% of the approved premium rate and (2) execute a promissory note for the remaining premium due. The promissory note must require payment in full within 15 months of its execution.

If the balance owed is not paid in full by its due date or a payment is more than 60 days past due, the act requires the agent to (1) file a civil court action seeking appropriate relief within 75 days of when the balance was due and (2) make a diligent effort to obtain judgment, unless good cause is shown for failing to do so (e. g. , the principal or indemnitor files for bankruptcy or service of process failed despite good faith efforts).

#### RECORD KEEPING AND ACCOUNTING FOR FUND (Section 5)

The act deems premiums, return premiums, or other funds an agent receives that belong to insurers or others to be trust funds received in a fiduciary capacity. The agent must account for and pay the funds to the insurer or person entitled to them according to the agent's contract with the insurer or managing general agent. The act prohibits any fees, expenses, or charges of any kind from being deducted from the return premiums, unless otherwise allowed under the act. ("Return premium" is any part of a premium that a surety bail bond agent is obligated to return to a principal or indemnitor.)

The act requires an agent to keep, and make available to the commissioner or his designee, books, accounts, and records as necessary to enable the commissioner to determine whether the agent is complying with the act. An agent must keep books, accounts, and records relating to premium payments for at least three years after payments are made. The act permits photographic and digital reproductions of records. An agent who unlawfully diverts or appropriates trust funds for his or her own use is guilty of larceny. (Larceny ranges from a Class C misdemeanor to a Class B felony, depending on the amount involved (see Table on Penalties).)

#### RECORD MAINTENANCE AND EXAMINATION (Section 6)

The act requires agents to maintain all records of bonds they executed or countersigned for at least three years after the insurer's liability ends. The records must be open at all times for the Insurance Department's, insurer's, or managing general agent's examination, inspection, and copying. The commissioner may require agents to provide the department information concerning their surety bail bond business at any time and in a way he specifies.

#### BUILD-UP FUNDS (Section 7)

The act requires a surety bail bond agent or managing general agent to post "build-up funds" with an insurer or managing general agent according to (1) his or her contract with the insurer or managing general agent or (2) the managing general agent's contract with the insurer, whichever is applicable. The act defines "build-up funds" as a percentage of the premium the agent receives to execute a bail bond that is held in a trust account by the insurer or managing general agent.

The insurer or managing general agent must establish an individual build-up trust account for the agent in a federally insured bank or savings and loan association located in Connecticut. It must be in (1) the name of the agent and the insurer or managing general agent or (2) a trust for the agent. The account must be open to the Insurance Department's inspection and examination at all times. The insurer or managing general agent must maintain an accounting of all build-up funds that designates the amounts collected on each bond executed.

Under the act, build-up funds must be used to compensate the insurer or managing general agent for any losses incurred in apprehending a defendant or paying forfeited bail bonds. The act prohibits build-up funds from exceeding 40% of the surety bail bond premium the insurer contractually authorizes the agent to write. Build-up funds received must be immediately deposited to the build-up trust account, and interest earned on the deposits must accrue to the surety bail bond agent.

The act specifies that build-up funds become due to the agent when the (1) agent's bail bond contract ends and (2) liabilities on the bail bonds for which the funds were posted are discharged. It requires an insurer or managing general agent to pay the funds, minus any expenses incurred, to the agent within six months after they are due.

### COLLATERAL SECURITY OR INDEMNITY (Section 8 and 9)

#### *Requirements and Restrictions*

The act allows a surety bail bond agent to accept collateral security or other indemnity on a bail bond and specifies related requirements and restrictions. The collateral or indemnity must (1) be reasonable in relation to the bond amount, (2) not be used for the agent's personal benefit or gain, and (3) be returned in the same condition as received. Acceptable forms of collateral or other indemnity include (1) cash or its equivalent, (2) a promissory note, (3) an indemnity agreement, (4) a real property mortgage in the insurer's name, or (5) any Uniform Commercial Code filing. If the agent receives collateral or other indemnity exceeding \$50,000 in cash, he or she must make the cash amount payable to the insurer using a cashier's check, U. S. postal money order, certificate of deposit, or wire transfer. But the act also specifies that when an agent receives bond collateral exceeding \$50,000 in cash or its equivalent, he or she must promptly forward the entire amount to the insurer or managing general agent.

The agent must provide the person putting up the collateral or indemnity a written, numbered receipt that includes a detailed description of the collateral or indemnity provided, along with copies of any documents rendered. The agent must hold the collateral or indemnity in a fiduciary capacity. Before any bond forfeiture, the agent must keep the collateral or indemnity separate and apart from any other funds or assets.

The act allows the agent to deposit collateral or other indemnity in an interest-bearing account in a federally insured bank or savings and loan association located in Connecticut. The interest accrues to the benefit of the person putting up the collateral or other indemnity. The act prohibits the agent, insurer, or managing general agent from receiving any pecuniary gain on the deposited collateral or other indemnity.

The act makes the insurer liable for all collateral or indemnity an agent receives. If, upon final termination of liability on a bond, the surety bail bond or managing general agent fails to return the collateral or other indemnity to the person that put it up, the act requires the insurer to (1) return the actual collateral or indemnity to that person or (2) if it cannot be located, pay the person its value. The insurer's liability survives the termination of a surety bail bond agent's appointment with respect to bonds the agent wrote before the termination.

If a bail bond is forfeited, the agent or insurer must give the bond's principal and the person who put up collateral or other indemnity 30 days' written notice that it will be converted into cash to satisfy the forfeiture. The notice must be sent by certified mail, return receipt requested, to their last-known addresses. If the court orders a stay of execution on the forfeiture in accordance with law, the agent or insurer must send the written notice at least 30 days before the stay expires.

The act requires the agent or insurer to convert the collateral or other indemnity into cash within a reasonable period of time and return to the principal or person who posted it any amount that exceeds the bail bond's face value, minus the actual and reasonable conversion expenses, which must not exceed 10% of the face value. If an agent spends

more than 10%, he or she may file a civil court action to recover the full amount of actual and reasonable expenses upon motion and proof that expenses exceeded 10%. If a bond is forfeited and the insurer paid the bond, the insurer must pay the person who put up the collateral or indemnity its value minus the actual and reasonable expenses that can be recovered.

Under the act, an agent or insurer cannot enter into any agreement as to the collateral's or indemnity's value that does not reflect its actual value. Any agreement that violates the act is void.

#### *Appointment Requirement*

Before an insurer appoints surety bail bond agents who are currently or were previously appointed by another insurer, the agents must file a sworn and notarized affidavit with the commissioner, on a form he prescribes, stating that:

1. they have not lost, misappropriated, converted, or stolen any collateral or indemnity they hold in trust for an appointing insurer;
2. all collateral or indemnity they hold in trust and all records for any appointing insurer are available for the commissioner's, insurer's, or managing general agent's immediate audit and inspection; and
3. they will, upon the commissioner's or insurer's demand, transmit the records to the insurer for whom the collateral or indemnity is being held in trust.

#### *Returning Collateral or Indemnity*

Under the act, if an agent accepted collateral or indemnity on a bond and the bond is terminated, the surety bail bond agent, managing general agent, or insurer must return it, except a promissory note or an indemnity agreement, within 21 days after (1) receiving a court's written report that the bond was terminated or (2) becoming aware that the bond was terminated even if, despite a managing agent's or insurer's diligent inquiry, the court does not issue a written report. The collateral or indemnity must be returned to the person who provided it, unless the right to receive it was legally assigned to another person. The act prohibits an insurer or agent from deducting a fee or other charge, other than one the act authorizes, from the collateral or indemnity due. Actual expenses incurred in apprehending a defendant because of a forfeiture of bond or judgment, if accounted for, may be deducted.

A person who violates the act's provisions regarding returning collateral or indemnity is guilty of larceny.

#### GIVING BAIL BOND SUPPLIES TO UNLICENSED PERSON PROHIBITED (Section 10)

The act prohibits an insurer, managing general agent, or surety bail bond agent from giving any blank form, application, stationery, business card, or other supplies used in soliciting, negotiating, or executing bail bonds to a person not licensed and appointed as a surety bail bond agent. But this does not prohibit an unlicensed employee under the direct supervision and control of a licensed and appointed agent from possessing or working with any form used in the agent's or insurer's daily business activities, other than a power of attorney, bond appearance form, or collateral security or indemnity receipt.

### *Insurer Liable*

The act makes an insurer that (1) gives supplies to an agent or other person the insurer has not appointed and (2) accepts bail bond business from or executes bail bond business for that person, liable on the bail bond to the same extent and in the same manner as if the insurer had appointed him or her to act on its behalf.

### PROHIBITED PRACTICES (Section 11)

The act prohibits an agent or insurer from:

1. suggesting, advising, or giving the name of, a particular attorney to represent the principal (i. e. , bail bond client) in exchange for a fee or other consideration;
2. “soliciting” business (see below) (a) in, or on the grounds of a correctional institution, community correctional center, or other detention facility where arrested people are confined or (b) in a police station or courthouse (PA 11-152, sections 16 and 17, changed this provision and allows solicitation in or on a police station’s property);
3. wearing or displaying any identification, other than an Insurance Department-issued or insurance commissioner-approved license or identification, in or on the grounds of a correctional institution, community correctional center, other detention facility where arrested people are confined, or courthouse (PA 11-152, sections 16 and 17, removes this prohibition from wearing or otherwise displaying identification other than their licenses on the property or grounds of a prison, community detention center, courthouse, or any other place of arrestee confinement);
4. acting as an attorney at a principal's proceeding in violation of law;
5. executing a bond in Connecticut (a) on the agent's or insurer's own behalf, (b) if a bond the agent executed is forfeited and the forfeiture has remained unpaid for at least 60 days after payment was due, unless the full amount of the forfeited bond is paid to the chief state's attorney's office, or (c) if the arrested person or someone authorized to act on the person's behalf has not authorized the agent to do so (the agent must keep the written authorization); and
6. accepting anything of value from a principal for providing a bail bond, other than the approved premium and an expense fee, except that the agent may accept collateral or indemnity.

The act permits an agent, upon written agreement with a third party, to receive a fee or other compensation for returning to custody a person who fled the court's jurisdiction or caused a bond forfeiture.

The act specifies that, for purposes of item 2 above, “solicit” includes distributing business cards, print advertising, or any other written information directed to arrested persons or potential indemnitors, unless an arrestee or indemnitor initiates contact. (PA 11-152 adds to this list, a person with actual or apparent authority to act on behalf of an arrestee. ) The act limits permissible print advertising in, or on the grounds of a correctional institution, community correctional center, other detention facility where arrested people are confined, police station, or court, to a (1) telephone directory listing and (2) posting of the surety bail bond agent's name, address, and telephone number in a prominent, designated location.

The act also prohibits an agent or insurer from paying a fee or rebate or giving or promising anything of value to:

1. a law enforcement officer, judicial marshal, Department of Correction employee, other person who has power to arrest or hold a person in custody, or public official or employee to secure a bail bond compromise, remission, reduction, or estreatment (i.e., enforcement of a bond forfeiture);
2. an attorney in a bail bond matter, except in defense of a bond action; or
3. the principal or anyone on his or her behalf.

### *Forfeiture*

If a bond written by an agent is forfeited and the forfeiture remains unpaid for at least 60 days after payment was due, the agent and the appointing insurer are prohibited from writing a bail bond in Connecticut until the full amount of the forfeited bail bond is paid to the Office of the Chief State's Attorney.

### REPORTING REQUIREMENTS (Section 12)

The act requires each insurer and surety bail bond agent executing bail bonds in Connecticut to maintain and report certain information to the Insurance Department upon request. An agent must (1) report the information to the department separately for each insurer he or she represents and (2) give a copy to each such insurer.

An insurer and agent must report the number and total dollar amount of:

1. bail bonds executed;
2. bail bonds ordered forfeited;
3. forfeitures discharged, remitted, or otherwise recovered before payment for any reason, including the agent's apprehension of the principal;
4. forfeited bonds not reinstated under law;
5. forfeitures paid and subsequently recovered by the Chief State's Attorney's Office; and
6. bail bonds for which collateral or other indemnity was received.

They must also report:

1. a list of every outstanding or unpaid forfeiture, estreatment, and judgment, including the case number and court for each, and the name of each agency or firm employing the surety bail bond agent;
2. the actual value of collateral security or other indemnity converted, excluding the cost of converting it;
3. the cost of converting collateral security or indemnity; and
4. additional information the Insurance Department may require to evaluate the (a) reasonableness of rates, ensuring that rates are not excessive, inadequate, or unfairly discriminatory, (b) financial condition or trade practices of agents and insurers executing bail bonds, and (c) performance of the surety bail bond agents and insurers executing bonds in accordance with appropriate criminal justice system goals and standards.

An insurer must also report:

1. commissions paid,
2. underwriting gain or loss, and
3. net investment gain or loss allocated to funds associated with Connecticut business.

### *Annual Meeting*

The act requires the commissioner to meet at least annually with a group of agents, insurers, and any other representatives he deems necessary to discuss these reporting requirements.

### PENALTY AND APPEALS (Section 13)

The act extends to its provisions, the commissioner's existing authority to suspend or revoke an agent's license, impose a penalty of up to \$5,000, or both, for violating the law. When an agent's license is surrendered, suspended, or revoked, the act requires the appointing insurer or managing general agent to designate immediately a licensed and appointed agent to administer the bail bonds the former agent executed.

By law, a person whose license the commissioner suspended or revoked, or whom the commissioner fined, may appeal. The act transfers the appeal venue from Hartford to the New Britain judicial district.

### REGULATIONS (Section 14)

The act authorizes the insurance commissioner to adopt regulations to implement the act's provisions relating to surety bail bond agents. Prior law required him to adopt regulations implementing licensing and appointment requirements.

### PROFESSIONAL BAIL BONDSMEN (Sections 16 to 22)

#### *Licensing and Notice to Courts and Others*

By law, a professional bail bondsman is someone who furnishes bail in five or more criminal cases a year, whether or not for compensation. A professional bondsman must be licensed by the Department of Public Safety (DPS), be a resident elector, and submit to a criminal history records check. A license applicant must provide DPS with personal information, including name, age, residence, and occupation. The act requires an applicant to also provide his or her telephone number.

The act requires a professional bondsman to give DPS written notice of a change in name, address, or telephone number within 30 days after the change.

By law, the DPS commissioner must give all courts and municipal departments authorized to accept bail a list of licensed professional bondsmen and notify them of any change in a bondsman's status. The act requires him also to (1) provide the bondsman's address and telephone number and (2) notify them of a change in the bondman's name, address, or telephone number.

By law, anyone who violates these provisions is subject to a fine of up to \$1,000, imprisonment of up to two years, or both and his or her license is permanently forfeited.

#### *Examination of Books*

The act permits the DPS commissioner to (1) examine a professional bondsman's books and records as often as he deems necessary and (2) consult with the insurance commissioner to carry out such inspections. It also authorizes the DPS commissioner to adopt regulations to (1) establish inspection procedures, (2) determine the content and form of books and records bondsmen must keep, and (3) require bondsmen to pay a fee to cover the cost of the inspections.

### *Regulations*

The act authorizes the DPS commissioner to adopt regulations to implement its provisions relating to professional bondsmen.

### *Prohibited Practices*

The act restricts bail bond solicitation by professional bondsmen in the same way as for surety bail bond agents (see § 11 on prohibited practices above), with two differences.

A professional bondsman cannot:

1. wear or display any identification, other than a DPS commissioner-approved or –issued license or identification, in or on the grounds of a correctional institution, community correctional center, other detention facility where arrested people are confined, or courthouse (PA 11-152 eliminates this prohibition) and
2. accept anything of value from a principal for providing a bail bond, other than the commission or fee authorized by law and collateral or indemnity in accordance with the act.

By law, a bondsman may charge up to \$50 for bond amounts up to \$500, 10% for amounts of \$500 to \$5,000, and 7% for amounts over \$5,000.

### *Forfeiture*

If a bond written by a bondman is forfeited and the forfeiture remains unpaid for at least 60 days after payment was due, the bondsman is prohibited from writing a bail bond in Connecticut until the full amount of the forfeited bail bond is paid to the Office of the Chief State's Attorney.

### *Collateral Security and Indemnity*

The act allows a professional bondsman to accept collateral security or indemnity on a bail bond.

Under the act, if a bondsman accepted collateral or indemnity on a bond and the bond is terminated, he or she must return the collateral or indemnity, except a promissory note or an indemnity agreement, within 21 days after (1) receiving a court's written report that a bond was terminated or (2) becoming aware that a bond was terminated even if, despite diligent inquiry, the court does not issue a written report. The collateral or indemnity must be returned to the person who provided it, unless the right to receive it was legally assigned to another person.

The act prohibits a bondsman from deducting a fee or other charge from the collateral or indemnity due, but actual and reasonable expenses incurred in apprehending a defendant because of a forfeiture of a bail bond or judgment, if accounted for, may be deducted.

A bondsman who violates these requirements is guilty of larceny.

### VERIFICATION OF OUTSTANDING WARRANTS (Section 23)

At the request of a licensed professional bondsman, surety bail bond agent, or bail enforcement agent during regular business hours, the act requires the Judicial Branch to verify whether a rearrest warrant or capias issued by a court after forfeiting a bond for failure to appear is still outstanding.

#### PRINCIPAL INCARCERATED IN ANOTHER JURISDICTION (Section 24)

The act requires the court to vacate an order forfeiting a bond and release the professional bondsman, surety bail bond agent, and insurer when the (1) principal is detained or incarcerated in another state, territory, or country; (2) professional bondsman, agent, or insurer provides the court and prosecutor with proof of detention or incarceration; and (3) prosecutor declines to seek extradition.

By law, when the court orders a bail bond forfeited and issues a rearrest warrant for failure to appear, the court stays execution of the bond forfeiture for six months.

#### **Public Act 11-61 (House Bill 6652, Sections 33 through 36) Act Implementing the Revenue Items in the Budget and Making Budget Adjustments, Deficiency Appropriations, Certain Revisions to Bills of the Current Session and Miscellaneous Changes to the General Statutes (Signed by the Governor 6/21/2011)**

#### NONADMITTED INSURANCE POLICIES AND PREMIUM TAXES (Sections 33-36)

Under prior law, the state imposed a 4% tax on gross premiums charged by nonadmitted (i.e., unauthorized) insurers on insurance policies procured independently or through licensed surplus lines brokers. In accordance with the 2010 federal Nonadmitted and Reinsurance Reform Act (NRRA), the act:

1. limits the policies subject to the tax,
2. modifies how individuals and brokers must pay the tax,
3. allows the revenue services and insurance commissioners to enter into an agreement with other states regarding the allocation of premium taxes among the states in cases where the policy covers multiple states, and
4. exempts certain commercial purchasers from certain filing requirements.

Under the NRRA, states must adopt, by July 21, 2011, uniform requirements and procedures for allocating and collecting premium taxes on nonadmitted insurance policies. The act requires that its provisions be construed so as to avoid preemption under the NRRA. It also modifies the penalty and interest due on unpaid tax payments.

#### *Nonadmitted Insurance Premium Tax*

*Applicability.* Under prior law, the 4% premium tax on independently procured unauthorized insurance (i. e. , policies not purchased through a broker) applied to any individual procuring, continuing, or renewing insurance with an unauthorized insurer on an insured risk that (1) resided, (2) was located, or (3) was performed in the state. The premium tax on policies procured through a licensed surplus lines broker applied to the gross premiums for all policies the broker sold, minus any premium amounts returned to policyholders.

To conform to NRRA provisions, the act limits the tax to any nonadmitted insurance policy procured directly or through a licensed surplus lines broker where Connecticut is the insured's home state. Under the NRRA, an insured's "home state" is the state where an insured maintains its principal place of business or residence. If the insured risk is

located entirely outside of the state in which the insured resides or maintains its principal place of business, the “home state” is the state to which the greatest percentage of the insured's taxable premium is allocated. In the case of an affiliated group insured on a single nonadmitted insurance contract, the “home state” is the state to which the largest percentage of premium is allocated.

By law, the tax on surplus lines broker premiums does not apply to policies issued to (1) the state, (2) any town, or (3) any special taxing district if any of these are named on the policy and responsible for paying its premiums. Also, by law, the tax on independently procured policies does not apply to (1) individual life or disability, (2) wet marine, or (3) transportation insurance. The act also makes a minor related change.

*Tax Administration.* Prior law required individuals who procured an insurance policy from a nonadmitted insurance company to withhold 4% of the premium for premium taxes, file an annual tax return, and remit the tax by March 1 to the Department of Revenue Services (DRS). Licensed surplus lines brokers (see BACKGROUND—*Surplus Lines Insurance*), on the other hand, had to file quarterly tax returns and remit the tax to the Insurance Department by the first day of February, May, August, and November. The act requires both individuals and brokers to file quarterly tax returns and remit the tax to DRS and the Insurance Department, respectively, by the 15<sup>th</sup> day of these months.

*Late Filing Penalty and Interest.* Under prior law, surplus lines brokers that failed to pay the premium tax were subject to a penalty of 10% of the tax due plus at least 1% interest for each full or partial month that the tax remained unpaid. The act makes the interest rate 1% and subjects individuals who fail to pay the tax on independently procured policies to the same penalty and interest. It eliminates the \$75 minimum penalty for independently procured policies.

Under prior law, the DRS commissioner could ask the attorney general to recover any delinquent taxes on independently procured policies. The act authorizes the attorney general to also recover any related interest and penalties. By law, the DRS commissioner may waive all or part of the penalty if he finds that the taxpayer's failure to pay the tax has a reasonable cause and is not intentional or due to neglect.

#### *Nonadmitted Insurance Premium Agreement*

The act allows the DRS and insurance commissioners to enter into a cooperative or reciprocal agreement with other states to allocate nonadmitted insurance premium taxes among them in accordance with the NIRA's requirements. The agreement may include the National Association of Insurance Commissioners' Nonadmitted Insurance Multistate Agreement (NIMA) (see BACKGROUND—*Nonadmitted Insurance Multistate Agreement*). Under the act, if the agreements' provisions differ from those in the act, the agreement prevails.

*Premium Allocation.* The agreement may provide a formula for allocating nonadmitted insurance premiums for policies that cover insured risks that are only partially in the state. For such policies, premiums allocated to Connecticut are subject to the state's 4%

tax; premiums allocated to other states that are a party to the agreement are subject to each state's respective tax rate. To the extent that a policy covers an insured risk in a state that is not a party to the agreement, the portion of gross premiums otherwise allocable to that state must be allocated to Connecticut.

*Administrative Requirements.* The agreement may include requirements or procedures for (1) recordkeeping, (2) audits, (3) information-sharing, (4) collecting delinquent taxes, (5) disbursing funds to other states in the agreement, and (6) any additional provisions that will facilitate its administration.

*Cooperative Agreements with Processing Entities.* The commissioners may enter into cooperative agreements with processing entities in Connecticut or any other state to collect and process nonadmitted insurance tax premiums and data.

*Disclosing Confidential Information.* Although the DRS and insurance commissioners are generally prohibited from disclosing tax return information, the act allows them to disclose such information on insured individuals under the agreement's terms. "Return information" includes a taxpayer's identity and the nature, source, or amount of the taxpayer's income, tax liability, and tax payments. The act also allows the insurance commissioner to disclose information on surplus lines brokers that is otherwise confidential under state law, under the agreement's terms.

Both commissioners may disclose the information to officials in (1) other states that are a party to the agreement and (2) entities that collect and process nonadmitted insurance premiums and related data, if their official duties require such information.

*Exemption from Diligent Search Requirements for Certain Commercial Purchasers*

The law requires the insurance commissioner to maintain, publish, and make available to surplus lines brokers a list of lines of insurance he believes are not available from admitted Connecticut insurers (i. e. , surplus lines insurance). By law, licensed surplus lines brokers and their clients that procure a type of insurance that is not on this list must file with the commissioner an affidavit that shows that they made diligent efforts to procure the full amount of the coverage from an admitted insurer.

The act exempts from this requirement any insurance policy a licensed surplus lines broker procures for an "exempt commercial purchaser," as defined in the NRRA (see BACKGROUND—*Exempt Commercial Purchaser*). In doing so, it aligns state law to the NRRA's requirements that certain commercial purchasers be exempt from state diligent search requirements.

Under the act and the NRRA, an exempt commercial purchaser is exempt from state diligent search requirements if (1) the broker procuring the insurance discloses to the purchaser that such insurance may or may not be available from an authorized insurer that may provide greater protection with more regulatory oversight and (2) the purchaser

subsequently requests, in writing, that the broker procure the policy from a nonadmitted insurer.

**EFFECTIVE DATE: Upon passage and applicable to nonadmitted insurance coverage procured, continued, or renewed on or after July 1, 2011.**

**Public Act 11-1, October 2011 Special Session (House Bill 6801-Sections 56 to 73)  
An Act Promoting Economic Growth and Job Creation in the State  
(Signed by the Governor 10/27/11)**

#### CAPTIVE INSURANCE COMPANIES

The act revises and expands PA 08-127, which permits a captive insurance company (“captive”) to be licensed and domiciled (have its principal place of business) in Connecticut. A captive is, in its simplest form, an insurance company that is (1) a wholly-owned subsidiary of another company and (2) whose primary function is to insure all or a part of its controlling company's risks. PA 08-127 enumerates requirements for a captive's formation, capital and surplus, local office presence, payment of certain fees and premium taxes, and annual reporting, among other things. (There are currently no captives domiciled in Connecticut.)

This act:

1. creates three new subgroups of captives that can do business in Connecticut (sponsored captive, special purpose financial captive, and branch captive) and expands the types of insurance a captive may transact in Connecticut;
2. establishes a reinsurance premium tax requirement (existing law already includes a premium tax on direct-written premiums);
3. requires 11% of all captive premium taxes (direct-written and reinsurance) to be transferred to the captive insurance regulatory and supervision account, which the act creates;
4. allows 2% of the premium taxes to be transferred to DECD to promote the captive industry;
5. establishes a \$7,500 nonrefundable tax credit for a captive's first taxable year;
6. requires captives to pay sales tax and ad valorem property taxes;
7. authorizes the insurance commissioner to adopt implementing regulations; and
8. makes related changes.

#### *Captive Insurers*

By law, a captive insurance company may apply to the insurance commissioner for a license to do business in Connecticut. Under existing law, a captive domiciled in Connecticut can be set up as a pure captive, an association captive, an industrial insured captive, or a risk retention group (RRG). The act also allows a captive to be set up as a sponsored captive, special purpose financial captive (SPFC), or branch captive.

*Sponsored Captive.* Under the act, a sponsored captive is a captive:

1. for which one or more sponsors provides the minimum required capital and surplus,
  2. formed and licensed under the act,
  3. that insures its participants' risks through separate participant contracts, and
  4. that funds its liability to each participant through one or more protected cells and segregates the assets of each protected cell from those of other protected cells and the captive's general account. (A protected cell is a separate account for each participant. )
- The act specifies that a RRG cannot be a sponsor or a participant of a sponsored captive. Associations, corporations, LLCs, partnerships, trusts, and other business entities may be participants in a sponsored captive.

*Special Purpose Financial Captive.* Under the act, an SPFC is a company that is licensed in accordance with the act's provisions. It appears that an SPFC can transact reinsurance and insurance securitizations. An insurance securitization is a transaction, including capital market offerings, that is effected through risk transfer instruments and facilitating administrative agreements. The transaction is used to fund a SPFC's obligations under a reinsurance contract.

*Branch Captive.* Under the act, a branch captive is any alien captive insurance company the commissioner licenses to transact insurance business in Connecticut through a business unit with its principal place of business here. An alien captive is a company formed under the jurisdiction of a foreign country.

#### *Type of Insurance*

The act expands the types of insurance a captive may transact in Connecticut. Under prior law, a captive could transact life insurance, annuity, health insurance, and commercial risk insurance business. The act instead allows a captive to transact any form of insurance not disapproved by the insurance commissioner or otherwise prohibited. The act also authorizes captives to provide excess workers' compensation insurance to its parent and affiliated companies and to reinsure the workers' compensation risks of a qualified self-insured plan of its parent and affiliated companies, unless prohibited by law. By law, captives cannot write auto or homeowners' insurance coverage.

#### *Miscellaneous Requirements*

By law, a captive domiciled in Connecticut must (1) hold at least one meeting in Connecticut each year, (2) maintain its principal place of business here, and (3) appoint a registered agent to accept service of process and otherwise act on its behalf here. Whenever the registered agent cannot with reasonable diligence be found at the captive's registered office, the insurance commissioner is the agent upon whom service may be made.

#### *License Application*

By law, a captive cannot engage in any insurance business in Connecticut until it obtains a license from the Insurance Department. To request a license, a captive must send the insurance commissioner (1) organizational documents; (2) a financial condition statement; and (3) a coverage description, including deductibles, limits, and rates. Each

applicant captive must maintain capital and surplus in specified amounts and give the commissioner evidence of (1) asset liquidity relative to its assumed risk; (2) adequate management expertise, experience, and character; (3) a sound operation plan; and (4) the adequacy of its insureds' loss prevention program.

*Special Purpose Financial Captive.* The act requires an SPFC applicant to file additional information with its license application. For example, an SPFC must include, with its plan of operation, (1) a complete description of all significant transactions (e. g. , reinsurance, reinsurance security arrangements, and securitizations) and all parties involved in issuing securities; (2) the source and form of its capital and surplus; (3) its proposed investment policy; (4) a description of its underwriting, reporting, and claims payment methods; (5) balance sheets and income statements illustrating adverse case scenarios; and (6) its proposed rate and method for discounting reserves, if applicable.

An SPFC applicant must also submit an affidavit from its president, vice president, treasurer, or chief financial officer stating that, to his or her best knowledge and belief, the (1) proposed organization complies with all applicable provisions of Connecticut's captive insurance law and (2) company's investment policy reflects the liquidity of assets and reasonable management of such assets.

An SPFC applicant must also include with its application a qualified legal counsel's opinion that the company's offer and sale of securities complies with federal and state securities laws.

*Sponsored Captive.* The act requires a sponsored captive applicant to file additional information with its license application. For example, a sponsored captive applicant must also file with the commissioner (1) a statement acknowledging that all its financial records will be available for the commissioner's examination, (2) all contracts or sample contracts between the company and its participants, and (3) evidence that expenses will be allocated fairly among its protected cells (i. e. , each separate account that a sponsored captive maintains for each participant).

Under the act, a sponsored captive may apply to be an SPFC. Such a company must comply with the provisions applicable to both a sponsored captive and an SPFC. If there is a conflict between those provisions, then the provisions that apply to an SPFC control.

#### *Confidentiality of License Application*

By law, the information a license applicant provides is confidential and can be made public only with the applicant's consent, with two exceptions. The information is discoverable in a civil action in which the company is a party if it is relevant and necessary to the case; unavailable elsewhere; and, for non-RRG captives, is the subject of a subpoena that a judicial or administrative judge issues. The commissioner can also give the information to insurance regulation officials in another state if the other state's (1) officials agree in writing to keep the information confidential and (2) laws require confidentiality.

### *License Application Fee*

By law, a captive applicant must pay the commissioner an \$800 captive license application fee. The insurance commissioner may retain legal, financial, and examination services at the captive's expense. The act specifies that the services are for the licensing and financial oversight of captives.

### *License Issuance*

In general, if the commissioner finds that the application complies with applicable law, he may issue a license to the captive, which must pay a \$375 initial license fee. The license expires on the next April 1, and the captive can renew it annually by paying a \$375 renewal fee.

Under the act, the commissioner may only issue a license to an SPFC to do reinsurance if he finds that the (1) proposed plan of operation provides for a reasonable and expected successful operation and is not hazardous to any ceding insurer, (2) terms of the reinsurance contract comply with the act's provisions, and (3) the insurance regulator of each ceding insurer's state of domicile has approved the transaction.

The act prohibits the commissioner from issuing a license to a branch captive unless the related alien captive grants him the authority to examine the alien captive in the jurisdiction in which it is formed.

### *Capital and Surplus*

The law specifies the amount of unimpaired capital and surplus a captive must maintain as a condition of licensure. The act reduces, from \$750,000 to \$500,000, the minimum amount an association captive must maintain. It requires a sponsored captive to maintain at least \$500,000. It requires an SPFC to maintain at least \$250,000. But it requires a sponsored captive licensed as an SPFC to maintain at least \$500,000.

The act requires a branch captive to maintain at least \$250,000. And, reserves on a branch captive's insurance or reinsurance policies may be issued or assumed through its branch operations (i.e., its business operations in Connecticut).

Table 7 shows the capital and surplus requirements by type of captive.

Table 7: Capital and Surplus Requirements for Captives

<i>Captive Type</i>	<i>Minimum Capital and Surplus</i>
Pure captive	\$250,000
Association captive	\$500,000 (\$750,000 under prior law)
Industrial insured captive	\$500,000
Risk retention group	\$1 million
Sponsored captive (new)	\$500,000
Special purpose financial captive (new)	\$250,000

Sponsored captive licensed as a special purpose financial captive (new)	\$500,000
Branch captive (new)	\$250,000

By law, the commissioner may adopt regulations to establish additional capital and surplus requirements based on the type, volume, and nature of insurance business transaction.

*Dividends or Other Distributions*

By law, a captive may not pay dividends from, or other distributions with respect to, capital or surplus without the commissioner's prior approval. His approval of an ongoing distribution plan must be conditioned on the captive keeping capital and surplus levels above those approved. The act prohibits an SPFC from declaring or paying a dividend or distribution if it would jeopardize the company's ability to fulfill its obligations under its securitization agreements, reinsurance contracts, or related transactions. ‘

*Incorporation and Formation*

By law, a pure captive can form as a stock insurer, nonprofit corporation, or a manager-managed LLC. An association captive, industrial insured captive, or RRG can be an LLC, a stock or reciprocal insurer, or a mutual corporation.

Under the act, a sponsored captive must form as a stock insurer, a mutual corporation, a nonprofit corporation, or a manager-managed LLC. One or more sponsors (e. g. , an association, corporation, LLC, partnership, or trust) may apply to form a sponsored captive. An RRG cannot be a sponsor or a participant of a sponsored captive.

Under the act, an SPFC can form as a stock insurer or a manager-managed LLC. An SPFC can reinsure risks of a ceding insurer (i. e. , an insurer that transfers its risks to the SPFC) and purchase reinsurance with the commissioner's prior approval. A captive that is, or will be, engaged in an insurance securitization on or after July 1, 2012, is deemed to be an SPFC. The commissioner may require that captive to come into compliance with all applicable SPFC requirements.

The act permits a branch captive in Connecticut to write only insurance or reinsurance of the employee benefit business of its parent and affiliated companies that are subject to the federal Employee Retirement Income Security Act (ERISA).

By law, a captive must have at least three incorporators or organizers, at least one of whom must be a Connecticut resident.

*Certificate of General Good*

By law, a captive formed as a corporation, reciprocal insurer, or LLC must ask the insurance commissioner for a certificate finding that the proposed company will promote the state's general good. To make this finding, the commissioner must consider (1) each incorporator's character, reputation, financial standing, and purposes; (2) each officer's

and director's character, reputation, financial responsibility, insurance experience, and business qualifications; and (3) other things he deems advisable.

By law, a captive formed as a corporation must give this certificate, along with its articles of incorporation and organization fee, to the secretary of the state. The law does not specify what a reciprocal insurer or LLC needs to do with its certificate. But an LLC must request a certificate before filing articles of incorporation with the secretary of the state.

Under the act, in the case of a branch captive, the alien captive must petition the insurance commissioner to issue a certificate finding that licensing and maintaining branch operations will promote the general good of the state. The alien captive may register to do business in Connecticut after the commissioner's certificate is issued. In deciding to issue the certificate, the commissioner must consider the character, reputation, financial responsibility, insurance expertise, and business qualifications of the officers and directors of the alien company.

#### *Annual Financial Report*

Prior law required a captive to give the insurance commissioner an annual financial report by March 1. For pure captives and industrial insured captives, the act delays the due date to March 15. The pure or industrial insured captive may ask in writing for the commissioner's approval to file the report at the end of its fiscal year instead of by March 15. If he agrees, the report is due within 75 days after the fiscal year ends, up from 60 days under prior law.

*Special Purpose Financial Captive.* The act requires the commissioner to establish an SPFC's annual report form and content. An SPFC must report using statutory accounting principles, unless the commissioner requires or approves the use of generally accepted accounting principles or another comprehensive basis of accounting. An SPFC may ask in writing for the commissioner's approval to file its report at the end of its fiscal year.

*Branch Captive.* The act requires a branch captive to give the commissioner, by March 1 annually, a copy of all reports and statements that must be filed under the laws of the alien captive's jurisdiction. Two executive directors must verify the reports and statements by oath. If the commissioner determines that these provide adequate information concerning the alien captive, he may waive the requirement to complete a separate annual financial report. A branch captive may ask in writing for the commissioner's approval to file the reports and statements at the end of its fiscal year. If the commissioner agrees, the reports and statements are due within 60 days after the end of the fiscal year.

#### *Examinations*

Under prior law, the commissioner or his designee had to visit and examine each captive at least once every five years or more often as he deems prudent. The act accelerates the examination frequency to at least once every three years or more often as he deems prudent. But, it also allows the commissioner to reduce the frequency to once every five

years if the captive undergoes a comprehensive annual audit by independent auditors approved by the commissioner.

Under the act, an examination of a branch captive is of the branch business and branch operations located in Connecticut, provided the branch captive annually gives the commissioner a certificate of compliance from the jurisdiction in which it is formed and demonstrates to the commissioner's satisfaction that it is operating in sound financial condition in accordance with that jurisdiction's applicable laws and regulations.

#### *License Suspension or Revocation*

By law, the commissioner may, for cause, (1) suspend, revoke, or refuse to renew a captive's license or (2) in addition to, or instead of, license suspension or revocation and after notice and hearing, fine the captive up to \$10,000. Under the act "for cause" includes:

1. insolvency or impairment of capital or surplus;
2. not maintaining the required amount of capital or surplus;
3. not submitting an annual financial or other lawfully required report;
4. not complying with its charter, bylaws, or other organizational document;
5. not submitting to or paying for examination;
6. using methods that render its operation detrimental or its condition unsound to the public or its policyholders; or
7. not complying with Connecticut's laws.

Under the act, the commissioner must notify an SPFC at least 30 days before suspending, revoking, or refusing to renew its license. The notice must include the basis for the action and the hearing date. But no prior notice or hearing is required if the reason for the action relates primarily to the company's financial condition or soundness or a deficiency in its assets. Further, the commissioner may amend or modify an SPFC's license only (1) with the SPFC's consent or (2) if the commissioner has clear and convincing evidence that the change is necessary to avoid irreparable harm to the SPFC or the ceding insurer.

#### *Taxes and Tax Credit*

*Premium Tax.* Under prior law, a captive had to pay premium taxes on its direct-written premiums to the revenue services commissioner annually in February. The act specifies that the taxes are due by March 1 annually.

The act adds a reinsurance premium tax requirement. In addition to paying taxes on its direct-written premiums, a captive must pay the revenue services commissioner, in March annually, a tax on its assumed reinsurance premium. The reinsurance premium tax does not apply to premiums subject to taxation on a direct-written basis. The reinsurance premium tax owed is 0.214% of the first \$20 million of assumed reinsurance premium, plus 0.143% of the next \$20 million, 0.048% of the next \$20 million, and 0.024% of each additional dollar.

Under the act, the annual minimum aggregate tax paid by a captive (other than a sponsored captive) is \$7,500 and the annual maximum aggregate tax is \$200,000. For a

branch captive, the annual aggregate tax applies only to the branch business of the captive transacted in Connecticut. For a sponsored captive, the annual minimum aggregate tax is \$7,500 and applies to the company as a whole, not to each protected cell. A sponsored captive's annual maximum aggregate tax is the aggregate tax liability on the direct-written premiums of each protected cell.

*Tax Credit.* Under the act, a captive licensed on or after January 1, 2012 will receive a nonrefundable tax credit of \$7,500 for its first taxable year. The revenue services commissioner must prescribe the form and manner for claiming the credit.

*Sales and Property Tax.* Under prior law, the state could not levy any tax against a captive except premium and property taxes. The act instead allows the state to levy premium, sales and use, and ad valorem property taxes against captives.

#### *Captive Insurance Regulatory and Supervision Account*

The act establishes the captive insurance regulatory and supervision account as a separate, nonlapsing account within the Insurance Fund for the Insurance Department's use to regulate captives.

The department must deposit all fees and assessments relating to captives in this account. The comptroller must also annually transfer 11% of total captive premium taxes collected to the account. The comptroller may, with the OPM secretary's approval, transfer up to 2% of the total premium taxes collected to DECD to use in promoting Connecticut's captive industry.

Payments cannot be made from the account “for the maintenance of staff or associated expenses, including contractual services as necessary” until the insurance commissioner receives proper documentation regarding the services rendered and expenses incurred. The commissioner must establish the form and manner of such documentation. Any balance remaining in the account at the fiscal year end is carried forward in the account for the next fiscal year.

#### *Other Applicable Laws*

By law, other specified insurance statutes apply to captives. The act adds the following to the list of applicable statutes:

1. CGS § 38a-8 (duties of the insurance commissioner),
2. CGS § 38a-73 (stock insurer's limitation on risks), and
3. CGS §§ 38a-129 to 38a-140 (acquisition of controlling interest).

#### *Mergers*

By law, state laws concerning mergers, consolidations, and conversions that apply to insurers generally also apply to captives. Under the act, the commissioner may permit a captive to form for the sole purpose of merging with an existing captive.

#### *Additional Provisions Applicable to Sponsored Captives*

Each sponsored captive may:

1. establish and maintain one or more protected cells, subject to specified conditions;
2. combine the assets of two or more protected cells for investment purposes;
3. establish and maintain one or more protected cells as a separate corporation or LLC;  
and
4. establish and maintain a protected cell as an incorporated protected cell.

Except as otherwise specified in the act, Chapter 704c of the general statutes, pertaining to administrative supervision and the conservation, rehabilitation, and liquidation of an insurer, also applies to sponsored captives. But, if a sponsored captive becomes insolvent and the commissioner determines that one or more protected cells remain solvent, he may separate those cells from the company and, on a sponsor's application, convert the cells into one or more new captives.

In general, a protected cell's assets cannot be used to pay any expenses or claims other than its own. A sponsored captive's capital and surplus must be available at all times to pay any expenses of or claims against it.

#### *Additional Provisions Applicable to SPFCs*

The act specifies numerous additional provisions applicable to SPFCs. For example, an SPFC must give the commissioner a copy of an insurance securitization's complete set of executed documentation within 30 days after the closing on the transaction.

Any change in the SPFC's plan of operation requires the commissioner's prior approval. An SPFC's transactions require the commissioner's prior approval in specified instances. An SPFC must give the commissioner prior notice of any change in the legal ownership of any security it issued.

The act specifies that an SPFC's security is not regulated as an insurance or reinsurance contract.

Unless previously approved by the commissioner, an SPFC cannot assume or retain exposure to insurance or reinsurance losses for its own account that are not funded by:

1. proceeds from an SPFC securitization, letters of credit, or other allowed assets;
2. premium and other amounts paid by the ceding insurer; and
3. any investment returns.

Under the act, an SPFC may enter into contracts and conduct other commercial activity related to reinsurance and securitization activities. An SPFC's assets must be preserved and administered to satisfy the SPFC's liabilities and obligations.

An SPFC's security offering memorandum or other document issued to prospective investors must disclose that all or part of the proceeds of the securitization will be used to fund the SPFC's obligations to the ceding insurer.

An SPFC is not subject to any investment restrictions, except:

1. an SPFC cannot make a loan to anyone other than those permitted under its plan of operation or as otherwise previously approved by the commissioner and
2. the commissioner may prohibit or limit any investment that threatens the solvency or liquidity of the SPFC unless the investment is otherwise approved in the plan of operation.

Unless previously approved by the commissioner, an SPFC must maintain its books and records in Connecticut and keep them available for examination until the commissioner approves their destruction. If the commissioner allows the SPFC to keep the books and records outside of Connecticut, the SPFC must keep a complete and true copy of them here.

*Additional Provisions Applicable to Sponsored Captives Licensed as SPFCs*

The act specifies numerous additional provisions applicable to a sponsored captive that is licensed as an SPFC. Among other things, unless previously approved by the commissioner, a participant in the captive must be a ceding insurer. Any change in a participant requires the commissioner's prior approval.

In connection with the conservation, rehabilitation, or liquidation of such a captive, the company must keep the assets and liabilities of a protected cell separate at all times from those of other protected cells. When issuing a security, contract, or obligation, the captive must designate the related protected cell and include a disclosure that the holder of the security, contract, or obligation has no right or recourse against the captive other than assets properly attributable to the designated cell. The captive must attribute assets and liabilities to the protected cells and general account according to its approved plan of operation. It must attribute all insurance obligations, assets, and liabilities relating to a reinsurance contract to such protected cell.

Except as otherwise specified in the act, Chapter 704c of the general statutes, pertaining to administrative supervision and the conservation, rehabilitation, and liquidation of insurers, applies to sponsored captives licensed as SPFCs. The commissioner may petition the Superior Court to authorize him to conserve, rehabilitate, or liquidate such a captive or one of its protected cells on one or more of the following grounds:

1. embezzlement, wrongful sequestration, dissipation, or diversion of the captive's assets;
2. insolvency; or
3. that the holders of a majority in outstanding principal amount of each class of securities attributable to each particular protected cell request or consent to conservation, rehabilitation, or liquidation.

In the event of the captive's insolvency, if the commissioner determines that one or more protected cells remain solvent, he must separate those cells from the company and, on a sponsor's application, convert the cells into one or more new captives.

**EFFECTIVE DATE: July 1, 2012. The tax provisions apply to calendar years beginning on or after January 1, 2012.**

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

**Public Act 11-19 (Senate Bill 849)**

**An Act Concerning the Legislative Commissioners' Recommendations for Technical Revisions and Minor Changes to the Insurance and Related Statutes  
(Signed by the Governor 5/24/11)**

This act broadens the applicability of various health insurance benefit requirements. It also makes numerous technical changes in the insurance statutes.

**EFFECTIVE DATE: January 1, 2012, except for some technical changes, which are effective July 1, 2011 or October 1, 2011.**

**HEALTH INSURANCE BENEFITS**

The act broadens the applicability of various health insurance benefits required by law, as summarized in Table 1. By doing so, the act applies the listed benefit requirements to individual and group health insurance policies delivered, issued, renewed, amended, or continued in the state. Most of the provisions apply to (1) individual and 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 cover limited benefits. (Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans. )

Table 1: Applicability of Health Insurance Benefits Expanded

<i>Act §</i>	<i>Benefit Requirement</i>	<i>Existing Law Applies to Policies</i>	<i>Act Expands Law to Apply to Policies</i>
33-34	Continuation of coverage of handicapped children	Delivered, Issued	Renewed, Amended, Continued
35	Coverage of newly born child – individual policies	Delivered, Issued, Renewed, Amended	Continued
36	Coverage of newly born child – group policies	Delivered, Issued, Amended	Renewed, Continued
37-38	Coverage for hypodermic needles and syringes	Delivered, Issued, Renewed	Amended, Continued
39-40	Coverage for off-label prescription drugs	Delivered, Issued, Renewed	Amended, Continued
41-44	Coverage for	Delivered,	Amended,

	home health care services	Issued, Renewed	Continued
45-46	Coverage for occupational therapy	Delivered, Issued, Renewed	Amended, Continued
47-48	Coverage for services of physician assistants and certain nurses	Delivered, Issued, Renewed	Amended, Continued
49-50	Direct access to obstetrician-gynecologist	Delivered, Issued, Renewed, Amended	Continued
51-52	Coverage for maternity care	Delivered, Issued, Renewed, Amended	Continued
53-54	Coverage for prescription contraceptives	Delivered, Issued, Renewed, Continued	Amended
55-56	Coverage for chiropractic services	Delivered, Issued, Renewed	Amended, Continued
57 and 62	Coverage for cancer clinical trials	Delivered, Issued, Renewed	Amended, Continued

**Public Act 11-38 (House Bill 6310)  
An Act Concerning Contracts with Ophthalmologists and Optometrists  
(Signed by the Governor 6/3/2011)**

This act requires an HMO or preferred provider network (PPN) that provides benefits for ophthalmologic and optometric services to provide ophthalmologists (licensed physicians specializing in ophthalmology) and optometrists equal access to all health plans and policies it offers. It prohibits an HMO or health insurer contracting with a PPN from restricting participation in a plan or policy based on the service limitations of individual optometrists or ophthalmologists. It also specifies that providing equal access to all health plans and policies does not permit any such provider to perform or provide services outside of his or her scope of practice.

Existing law requires an HMO or PPN providing ophthalmologic care benefits to also provide optometric care. If ophthalmologic care can be legally provided by an optometrist, then the HMO or PPN must provide the same eye care coverage and benefits for services they perform. HMOs and PPNs must contract with both types of specialists

in a fair and sufficient manner and equally inform enrollees of the availability of ophthalmologic and optometric services.

**EFFECTIVE DATE: January 1, 2012**

**Public Act 11-44 (Senate Bill 1240, Sections 147 & 148)  
An Act Concerning the Bureau of Rehabilitative Services and Implementation of Provisions of the Budget Concerning Human Services and Public Health  
(Signed by Governor 6/13/11)**

BIRTH-TO-THREE SERVICES FOR CHILDREN WITH AUTISM SPECTRUM DISORDERS

The act makes changes to the requirements for individual and group health insurance policies that provide coverage for medically necessary early intervention (birth-to-three services) provided as part of an individualized family service plan. It prohibits these policies from imposing co-insurance, copayments, deductibles, or other out-of-pocket expenses for these services, unless they are high-deductible policies designed to be compatible with federally qualified health savings accounts.

It also increases the annual maximum benefit that group health insurers must provide for children with autism spectrum disorders who receive birth-to-three services.

*Coverage Requirements*

By law, group health insurance policies must cover medically necessary birth-to-three services provided as part of an individualized family service plan for children with developmental delays. This coverage must include an annual maximum policy benefit of \$6,400 per child, with an aggregate benefit of \$19,200 per child over the three-year period. The act expands these coverage amounts for children with autism spectrum disorders to \$50,000 per child per year and \$150,000 per child over the three-year period. The act specifies that coverage provided through a birth-to-three individualized service plan must (1) be credited toward these coverage amounts in other statutes mandating autism coverage and (2) not increase these coverage amounts.

*Act's Applicability*

The act applies to health insurance policies delivered, issued, or renewed 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 the federal Employee Retirement and Income Security Act, state health insurance mandates do not apply to self-insured plans.

**EFFECTIVE DATE: January 1, 2012**

**Public Act 11-53 (Senate Bill 921)  
An Act Establishing a State Health Insurance Exchange  
(Signed by the Governor 7/1/2011)**

This act establishes the Connecticut Health Insurance Exchange as a quasi-public agency to satisfy requirements of the federal Patient Protection and Affordable Care Act (“PPACA”). Under the act, a 14-member board manages the exchange, including operating an online marketplace where individuals and small employers (i. e. , those with up to 50 employees) can compare and purchase health insurance plans that meet federal requirements beginning in 2014.

**EFFECTIVE DATE: Upon passage**

EXCHANGE CREATION (Sections 2, 15 – 18)

The act creates the Connecticut Health Insurance Exchange (exchange) as a quasi-public agency and adds the exchange to the statutes governing quasi-public agencies. The exchange is not a state department, institution, or agency.

*Board Membership*

The act vests the powers of the exchange in a 14-member board of directors, which includes the (1) insurance and public health commissioners and the healthcare advocate, or their designees, as ex-officio, nonvoting members and (2) social services commissioner, special advisor to the governor on healthcare reform, and Office of Policy and Management (OPM) secretary, or their designees, as ex-officio, voting members. The remaining eight voting board members must be appointed by the governor and the legislative leaders by July 1, 2011. If an appointing authority fails to make an appointment, the appointed board members can make the appointment by majority vote. Table 1 shows appointees and their respective qualifications and initial term.

Table 1: Appointed Exchange Board Members

<i>Appointing Authority</i>	<i>Required Expertise</i>	<i>Initial Term</i>
Governor	Individual health insurance coverage	Three years
Governor	Small employer health insurance coverage	Two years
Senate president pro tempore	Health care finance	Four years
House speaker	Health care benefits plan administration	Four years
Senate majority leader	Health care delivery systems	Two years
House majority leader	Health care economics	One year
Senate minority leader	Self-employed individuals' healthcare access issues	Three years
House minority leader	Barriers to individual health care coverage	Two years

After the initial terms expire, all subsequent terms are four years. Vacancies must be filled by the appointing authority for the rest of the term. Members can be reappointed. Members can be removed by the appointing authority for misfeasance, malfeasance, or willful neglect of duty. Members are not compensated, but may be reimbursed for

expenses incurred in performing official duties. Appointed members may not designate a representative to perform in their absence.

### *Qualifications*

While serving in their positions, appointees cannot be employed by, serve as a consultant to, or be affiliated with an insurer, insurance producer or broker, health care provider, health care facility, or health or medical clinic. Board members cannot be a member of, a board member, or an employee of, a trade association of insurers, insurance producers or brokers, health care providers, health care facilities, or health or medical clinics. They cannot be health care providers unless they do not receive compensation as providers and do not have an ownership interest in a professional health care practice.

As a condition of qualifying for the board of directors, an appointee must take the state Constitution oath or affirmation. A record of the oath must be filed in the Secretary of the State's Office. Members may engage in private employment or in a profession or business, subject to any federal or state laws, regulations, and rules regarding ethics and conflict of interest.

The act specifies that it does not constitute a conflict of interest for a trustee, director, partner, or officer of any person, firm, or corporation, or any individual having a financial interest in the person, firm, or corporation, to serve as an exchange board member. But such a member must abstain from any deliberation, action, or vote relating to the person, firm, or corporation.

### *Surety Bond*

The act requires (1) each board member to execute a \$50,000 surety bond or (2) the chairperson to execute a blanket position bond covering each board member, the chief executive officer (see below), and employees of the exchange. Each bond must be (1) conditioned on the faithful performance of duties, (2) written by a surety company authorized to transact business in Connecticut, (3) approved by the attorney general, and (4) filed with the secretary of the state. The exchange must pay the cost of each bond.

### *Noncompete Clause*

A board member cannot, for one year after serving on the board, accept a job with any health carrier that offers a qualified health benefit plan through the exchange. ("Health carrier" is an entity that provides, delivers, pays for, or reimburses the costs of health care services. It includes an insurer, HMO, fraternal benefit society, hospital or medical service corporation, or other entity subject to Connecticut's insurance laws and regulations or the insurance commissioner's jurisdiction.)

### *Chairperson and Meetings*

The act requires the governor to select a board chairperson from among the members. The board members must annually select a vice-chairperson. The chairperson must hold the first board meeting by August 1, 2011. Meetings must be held at times specified in the bylaws adopted by the board and at other times as the chairperson deems necessary.

Any member who fails to attend at least three consecutive meetings or half of all meetings during a calendar year is deemed to have resigned.

#### *Quorum*

The exchange may act by majority vote at any meeting at which there is a quorum. Six board members constitute a quorum to transact business or exercise any power of the exchange. A vacancy in the board membership does not impair the board's rights to transact business. Any board action taken may be authorized by resolution approved by a majority of the board members present and the resolution takes effect immediately, unless it provides otherwise.

#### *Chief Executive Officer*

The act requires the board to nominate three candidates for the initial chief executive officer (CEO) to the governor, who must choose one of the nominees. The board will select and appoint future CEOs. The CEO administers the exchange's programs and activities in accordance with the board's policies and objectives. The CEO may hire other employees as designated by the board.

#### *Employees of the Exchange*

*Qualifications.* An exchange employee cannot be a member of, a board member, or an employee of a trade association of insurers, insurance producers or brokers, health care providers, health care facilities, or health or medical clinics. They cannot be health care providers unless they (1) receive no compensation as providers or the CEO approves the hiring because the provider fills an area of needed expertise for the exchange and (2) do not have an ownership interest in a professional health care practice.

*Noncompete Clause.* An exchange employee cannot, for one year after working with the exchange, accept a job with any health carrier that offers a qualified health benefit plan through the exchange.

*Licensed Producer.* An exchange employee who sells, solicits, or negotiates insurance, or will do so, to individuals and small employers must be licensed as an insurance producer as required by law, within one year after starting to work with the exchange. (PA 11-61, § 142 instead requires exchange employees whose primary purpose is to assist individuals or small employers in selecting health insurance plans offered on the exchange to become licensed insurance producers within 18 months of starting work for the exchange. )

#### *Consultation*

The act allows the board to consult with public or private parties it deems necessary or desirable in performing its duties.

#### *Advisory Committees*

The act authorizes the board to create advisory committees it deems necessary to provide input on issues, including customer service needs and insurance producer concerns.

### WRITTEN PROCEDURES (Section 3)

The board must adopt written procedures in accordance with quasi-public agency law, which requires published notice before action, for:

1. adopting an annual budget and plan of operations, including a requirement for board approval before either may take effect;
2. hiring, dismissing, promoting, and compensating the exchange's employees, including an affirmative action policy and a requirement for board approval before a position may be created or vacancy filled;
3. acquiring real and personal property and personal services, including a requirement for board approval of any nonbudgeted expenditure over \$5,000;
4. contracting for financial, legal, bond, underwriting, and other professional services, including a requirement that the exchange solicit proposals at least once every three years for each service it uses;
5. issuing and retiring bonds, bond anticipation notes, and other obligations of the exchange;
6. establishing requirements for certifying qualified health plans, including minimum standards for marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and coverage descriptions, and quality measures for health benefit plan performance; and
7. implementing the act or other provisions of state law, provided they do not conflict with regulations adopted by the U. S. Health and Human Services (HHS) secretary.

### FORWARDING COPY OF AUDIT (Section 4)

The act requires the board to submit to the Insurance and Real Estate Committee a copy of each audit of the exchange conducted by an independent auditing firm within seven days of receiving the audit.

### PURPOSES OF THE EXCHANGE (Section 5)

The act specifies the purposes of the exchange and permits public funds to be spent to carry them out. It specifies that the exchange's goals are to reduce the number of people without health insurance in Connecticut and help individuals and small employers obtain health insurance by, among other things, offering easily comparable and understandable information about health insurance options.

Under the act, the exchange can:

1. have perpetual succession as a body politic and corporate;
2. adopt bylaws;
3. adopt an official seal and alter it;
4. establish a state office;
5. employ staff, including assistants, agents, and managers, as necessary;
6. acquire, own, manage, hold, and dispose of real and personal property and lease, convey, deal, or enter into agreements concerning such property on any terms necessary to carry out the exchange's purposes, except acquisitions of real property that use state-appropriated funds or bond proceeds backed by the state's full faith and credit are subject to the OPM secretary's approval and in accordance with state law (CGS § 4b-23);
7. receive and accept aid or contributions of any kind from any source;

8. charge assessments or user fees to health carriers capable of offering a qualified health plan through the exchange or otherwise generate funding necessary to support the exchange;
9. obtain insurance against loss concerning its property and other assets;
10. invest its funds in U. S. - or state-issued or -guaranteed obligations and in obligations that are legal investments for savings banks in Connecticut;
11. issue, fund, or refund bonds, bond anticipation notes, and other obligations of the exchange to fund any of its corporate purposes;
12. borrow money to obtain working capital;
13. account for and audit exchange funds and any recipients of exchange funds;
14. enter into contracts or agreements necessary to perform its duties, but such contracts are not subject to approval of any state agency as long as they are made public records, subject to the proprietary rights of any party to the contract;
15. if permitted under its contracts, agree to any termination, modification, forgiveness, or other change of any term of any contractual right, payment, royalty, contract, or agreement;
16. award grants to “navigators” (see § 9);
17. limit the number of plans offered, using selective criteria in determining which plans to offer through the exchange, provided there is an adequate number and selection;
18. with the Sustinet Health Care Cabinet (created by PA 11-53), evaluate the feasibility of implementing a basic health program option as provided for in federal law;
19. sue, be sued, implead, and be impleaded;
20. adopt procedures that do not conflict with state law; and
21. do all acts necessary and convenient to carry out its purposes, provided they do not conflict with the PPACA or related regulations and guidance. ‘

#### DUTIES OF THE EXCHANGE (Section 6)

Under the act, the exchange must:

1. administer the exchange for both qualified individuals and qualified employers;
2. survey individuals, small employers, and health care providers on health care and health care coverage issues;
3. implement procedures for certifying, recertifying, and decertifying health benefit plans as qualified health plans, consistent with the act and HHS guidelines;
4. operate a toll-free consumer assistance hotline;
5. provide for enrollment periods as provided in the PPACA;
6. maintain an Internet website through which people may obtain standardized comparative information on qualified health plans, including enrollee satisfaction survey information and other tools to assist in evaluating the plans;
7. publish on its website the average costs of licensing, regulatory fees, and any other payments the exchange requires and the exchange's administrative costs, including information on amounts lost to waste, fraud, and abuse;
8. rate each qualified health plan offered through the exchange and determine each plan's level of coverage in accordance with HHS criteria and regulations;
9. use a standardized format for presenting health benefit options in the exchange;

10. screen applications to determine if applicants are eligible for Medicaid, the State Children's Health Insurance Program, or other state public insurance programs and enroll eligible applicants in such programs;
11. to the extent possible, collaborate with the Department of Social Services (DSS) to allow a person to stay enrolled in his or her plan and provider network if he or she loses premium tax credit eligibility and becomes eligible for Medicaid;
12. establish and make available electronically a calculator that allows individuals to determine their actual cost of coverage, taking into consideration any applicable federal premium tax credit and cost-sharing reduction;
13. establish a program for small employers through which qualified employers may access coverage for their employees and specify a level of coverage so that their employees may enroll in any qualified health plan offered through the exchange at that specified level of coverage;
14. offer enrollees and small employers the option of having the exchange collect and administer premiums, including by allocating premiums among the various insurers and qualified health plans;
15. certify if an individual is exempt from the PPACA requirement to carry health insurance or from the penalty for not doing so;
16. provide to the U. S. Treasury secretary the name and taxpayer identification number of each individual who (a) was granted an exemption, (b) was eligible for the premium tax credit because his or her employer did not provide minimum essential health benefits coverage or provided coverage that was unaffordable or did not meet the required actuarial value, (c) notifies the exchange that he or she has changed employers, and (d) ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;
17. give each employer the name of each employee who was eligible for a premium tax credit and ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;
18. determine eligibility for premium tax credits, reduced cost-sharing, or insurance purchase mandate exemptions as required by HHS or the treasury department;
19. select entities qualified to serve as navigators under PPACA and under the act (see § 9);
20. review the rate of premium growth within and outside the exchange and consider that information when developing recommendations on whether to continue limiting qualified employer status to small employers;
21. credit the amount of any “free choice voucher” that may be available under PPACA to the monthly premium of the plan in which a qualified employee is enrolled and collect the amount credited from the offering employer; and
22. seek to include the most comprehensive health benefit plans that offer high quality benefits at the most affordable price in the exchange.

### *Stakeholders*

The exchange must consult with stakeholders relevant to implementing the act, including:

1. enrollees in qualified health plans who are knowledgeable about the health care system and have background and experience in making informed decisions on health, medical, and scientific matters;

2. people and entities experienced in facilitating enrollment in qualified health plans;
3. representatives of small employers and self-employed individuals;
4. DSS; and
5. advocates for enrolling hard-to-reach populations.

#### *Financial Integrity and Reporting*

The exchange must meet the following financial integrity requirements:

1. accurately account for all activities, receipts, and expenditures and annually report on these to HHS, the governor, insurance commissioner, and legislature;
2. fully cooperate with any HHS investigation and allow HHS to (a) investigate the exchange's affairs, (b) examine its properties and records, and (c) require periodic reports of its activities; and
3. ensure that its funds are not spent for staff retreats, promotional giveaways, excessive executive compensation, or state or federal lobbying.

#### *Adverse Selection Report*

The exchange must report at least annually to the legislature on the effect of adverse selection on the exchange's operations and make legislative recommendations, if needed, to reduce the negative impact of adverse selection on the exchange's sustainability. The recommendations must include ways to ensure that the regulation of insurers and health benefit plans are similar for qualified health plans offered through the exchange and health benefit plans offered outside the exchange. The exchange must evaluate whether adverse selection is occurring with respect to health benefit plans that are grandfathered under the PPACA, self-insured plans, plans sold through the exchange, and plans sold outside the exchange.

#### QUALIFIED HEALTH PLANS (Sections 7 & 8)

The act requires the exchange to make qualified health plans available to qualified individuals and employers by January 1, 2014. The exchange cannot make plans available unless they are qualified health plans.

The act defines a “qualified health plan” as a health benefit plan certified as meeting criteria outlined in the PPACA and this act. A “qualified individual” is a state resident seeking to enroll in a qualified health plan offered to individuals through the exchange who is a U. S. citizen, national, or lawful alien and not incarcerated (except for pretrial inmates). A “qualified employer” is a small employer with its principal place of business in Connecticut that elects to make its full-time employees eligible for one or more qualified health plans offered through the exchange. The employer also may elect to make some or all part-time employees eligible. The employer must provide coverage through the exchange to either all its eligible employees wherever they work or all its eligible employees employed in Connecticut.

The exchange must allow a health carrier to offer a limited scope dental plan, either separately or as part of a qualified health plan, if it covers pediatric dental benefits.

Under the act, the exchange or a health carrier offering plans through the exchange cannot charge an individual a coverage termination fee or penalty if the individual enrolls in another type of minimum essential coverage because he or she is newly eligible for the coverage or the individual's employer-sponsored coverage has become affordable under federal standards.

#### *Certifying Qualified Health Plans*

The act authorizes the exchange to certify a health benefit plan as a qualified health plan if:

1. the plan provides the federally designated essential health benefits (but a plan does not have to contain all essential health benefits if it is a qualified dental plan and the health carrier prominently discloses that (1) the plan does not provide all essential pediatric benefits and (2) qualified dental plans with those benefits are offered through the exchange);
2. the insurance commissioner has approved the premium rates and contract language;
3. the plan provides at least a “bronze” level of coverage (covering 60% of the cost of essential health benefits) unless it is certified as a catastrophic plan and offered only to people eligible for such plans (e. g. , under age 30 or exempt from the PPACA's requirement to carry health insurance);
4. the plan complies with federal limits on out-of-pocket costs;
5. the plan meets the exchange's certification requirements and those in HHS regulations; and
6. the exchange determines that making the plan available is in the interests of qualified individuals and employers in the state.

Under the act, the exchange cannot refuse to certify a plan (1) because it is a fee-for-service plan, (2) by imposing premium price controls, or (3) because it believes the plan provides treatments to prevent patients' deaths in circumstances that are too costly or inappropriate.

The exchange cannot exempt any health carrier from state licensure or reserve requirements and must apply the certification criteria in a way that assures a level playing field among health carriers participating in the exchange.

#### *Health Carrier Requirements*

To be eligible to offer qualified health plans through the exchange, a health carrier must:

1. be licensed and in good standing to offer health insurance in Connecticut;
2. offer through the exchange at least one plan at the “silver” coverage level (covering 70% of the cost of essential health benefits) and one plan at the “gold” coverage level (covering 80% of the cost of essential health benefits) through each exchange in which it participates (i. e. , the exchange for individuals and the exchange for small employers);
3. charge the same premium rate for each qualified health plan whether offered (a) through the exchange or outside it or (b) directly by the carrier or through an insurance producer;

4. charge no coverage termination fee or penalty if an individual enrolls in another type of minimum essential coverage because he or she is newly eligible for the coverage or his or her employer-sponsored coverage has become affordable under federal standards; and
5. comply with HHS regulations and any other requirements the exchange may establish.

A health carrier must agree to submit (presumably to the exchange) and post on its website a justification for any premium increase before implementing the increase. (The act does not specify how long before implementing an increase the carrier must submit this information. ) The exchange must consider such justification, along with (1) any additional information from the insurance commissioner and (2) any excess premium growth outside the exchange as compared to the rate of such growth inside the exchange, when determining whether to allow the carrier to continue making the plan available through the exchange.

A health carrier must disclose information in plain language to the public, the exchange, HHS, and the insurance commissioner, including information on claims, finances, enrollment, rating practices, out-of-network coverage cost sharing, enrollee rights under PPACA, and other information HHS requires.

A health carrier also must inform individuals, upon request, of the amount of cost sharing (e. g. , deductibles, copayments, and coinsurance) they are responsible for under their plans for specific services.

#### *Qualified Dental Plans*

The act applies to qualified dental plans, except as modified by the exchange's adopted, written procedures or the following:

1. a health carrier seeking certification of a dental plan as a qualified dental plan must be licensed in Connecticut to offer dental coverage but does not need to be licensed to offer other health benefits;
2. qualified dental plans are limited to dental and oral health benefits and must include, at a minimum, the essential pediatric dental benefits defined by HHS and other dental benefits as the exchange or HHS may specify; and
3. health carriers may jointly offer a comprehensive plan through the exchange in which dental benefits are provided by one carrier and health benefits by another carrier, as long as the plans are qualified plans and priced and made available for purchase separately. ]

#### NAVIGATORS (Section 9)

The act requires the exchange to establish a “navigator” grant program to award grants to certain entities to market the exchange. The exchange must establish performance standards, accountability requirements, and maximum grant amounts.

#### *Purpose*

A navigator must:

1. educate the public about the availability of qualified health plans sold through the exchange;

2. distribute fair and impartial information about enrollment in qualified health plans and the availability of premium tax credits and cost-sharing reductions under the federal PPACA;
3. facilitate enrollment in qualified health plans;
4. refer individuals with a grievance, complaint, or question about a plan, a plan's coverage, or a determination under a plan's coverage to the healthcare advocate or any customer relations unit the exchange establishes; and
5. provide information in a culturally and linguistically appropriate manner.

#### *Entities Allowed as Navigators*

The act requires the exchange board to award navigator grants at the board's sole discretion to any of the following:

1. a trade, industry, or professional association;
2. a community and consumer-focused nonprofit group;
3. a chamber of commerce;
4. a labor union;
5. a small business development center; or
6. an insurance producer or broker licensed in Connecticut.

Under the act, a navigator cannot be an insurer or receive any consideration directly or indirectly from an insurer for enrolling people in a qualified health plan.

To be considered for a navigator award, an entity must demonstrate to the board's satisfaction that it has, or could develop, relationships with small employers, their employees, and individuals, including underinsured, uninsured, or self-insured individuals.

#### *Miscellaneous*

The act requires a navigator to comply with the PPACA and related federal regulations and guidance and it requires the exchange to collaborate with HHS to develop standards that ensure the information navigators provide is fair and accurate.

#### STATE PLEDGE REGARDING CONTRACTUAL OBLIGATIONS (Section 10)

Under the act, the state pledges that it will not limit or alter any rights vested in the exchange until the exchange's contractual obligations to any person are fully met. But nothing precludes limitation or alteration if the law adequately protects those entering into contracts with the exchange.

#### TAX EXEMPTION (Section 11)

The act exempts the exchange from state and municipal franchise, corporate business, and property taxes. But it does not exempt (1) a person entering into a contract with the exchange from the taxes or (2) the exchange from any manufacture or sales taxes.

## ANNUAL REPORTING REQUIREMENTS (Section 12)

The act requires the exchange's CEO to report to the governor and legislature annually by January 1, 2012, 2013, and 2014, on the exchange in Connecticut. The report must address whether to:

1. establish separate exchanges for individuals and small employers or one combined exchange,
2. merge the individual and small employer health markets,
3. revise the definition of "small employer" from 50 to 100 employees,
4. allow large employers to participate in the exchange starting in 2017,
5. require qualified health plans to provide only the federally defined essential health benefits package or to also include additional state mandated benefits, and
6. list dental benefits separately on the exchange's website where a qualified health plan includes dental benefits.

The report also must address:

1. the relationship between the exchange and insurance producers;
2. the exchange's capacity to award navigator grants;
3. ways to ensure the exchange is financially sustainable by 2015 (as required by PPACA), including assessments or user fees charged to carriers; and
4. ways to independently evaluate consumers' experience, including hiring "secret shoppers."

The act also requires the exchange's CEO to report to the governor and legislature annually, beginning January 1, 2012, on:

1. any private or federal funds received during the prior calendar year and how they were spent,
2. the adequacy of federal funds for the exchange before January 1, 2015,
3. the amounts and recipients of any grants awarded (presumably navigator grants), and
4. the exchange's current financial status.

## MISCELLANEOUS REQUIREMENTS (Section 13)

### *Exchange's Legal Authority*

The exchange continues as long as it has legal authority to exist under the general statutes and until it is terminated by law. Upon termination, all its rights and properties pass to and are vested in the state.

### *Freedom of Information Act*

The exchange is subject to the Freedom of Information Act, except the following information is not subject to disclosure:

1. the names and applications of individuals and employers seeking coverage through the exchange;
2. individuals' health information; and
3. information shared between the exchange and the departments of Social Services, Public Health, and Revenue Services; the Insurance Department; the comptroller; or any other state agency that is subject to confidentiality agreements under contracts entered into under the act.

### *INSURANCE COMMISSIONER'S AUTHORITY*

Unless expressly specified, the act and the exchange's actions do not preempt or supersede the insurance commissioner's authority to regulate insurance in Connecticut. All health carriers offering qualified health plans in Connecticut must comply with all applicable state health insurance laws and regulations and the insurance commissioner's orders.

### ESSENTIAL HEALTH BENEFITS PACKAGE (Section 14)

The Office of Health Reform and Innovation (created by PA 11-58), in consultation with the exchange's board of directors and the Appropriations and Insurance and Real Estate committees, must prepare (1) an analysis of the cost impact on Connecticut and (2) a cost-benefit analysis of the essential health benefits package, as described in the PPACA and coverage requirements under chapter 700c of the general statutes. The analysis must consider regulations issued by the HHS secretary and any applicable health benefit review report performed by the Insurance Department pursuant to state law. Within 60 days after the HHS secretary publishes the essential health benefits, the Office of Health Reform and Innovation must submit its analysis to the governor, the exchange's board of directors, and the Appropriations and Insurance and Real Estate committees.

### **Public Act 11-58 (House Bill 6308) An Act Concerning Healthcare Reform (Became law, not signed by the Governor 7/1/11)**

This act:

1. requires the comptroller to offer employee and retiree coverage under “partnership plans” to (a) nonstate public employers beginning January 1, 2012 and (b) nonprofit employers beginning January 1, 2013 (Sections 1 to 8);
2. requires certain municipal employers that sponsor fully insured group health insurance policies or plans for their active employees and retirees to submit, by October 1 annually, certain information to the comptroller (Section 9);
3. allows municipal employers to give certain claims data they request from health insurers to the comptroller upon his request and requires that the information be kept confidential (Section 10);
4. establishes the (a) Office of Health Reform and Innovation (OHRI) (Section 11) and (b) SustiNet Health Care Cabinet in the lieutenant governor's office (Section 14);
5. requires OHRI to convene a working group concerning a statewide multipayer data initiative (Section 13);
6. requires (a) hospitals to submit patient-identifiable and emergency department data to the Office of Health Care Access (OHCA) which must keep it confidential, (b) certain facilities providing outpatient services to provide data to OHCA, and (c) OHCA to convene a working group addressing patient-identifiable data reporting in the outpatient setting (Section 12);
7. makes a variety of changes in laws relating to contracts between health care providers and health insurers (Sections 15 to 19);

8. requires the Insurance Department to license and regulate third-party administrators (TPA) (Sections 20 to 36); (SEE SUMMARY UNDER ACTS PROPOSED BY THE INSURANCE DEPARTMENT)
9. changes various health insurance statutes to conform with the 2010 federal Patient Protection and Affordable Care Act (PPACA), including covering dependents until age 26, not denying coverage to children under age 19 because of preexisting conditions, and eliminating lifetime benefit maximums (Sections 37 to 53) (SEE SUMMARY UNDER ACTS PROPOSED BY THE INSURANCE DEPARTMENT-Section 53), and;
10. revises the health insurance utilization review, grievance, and external appeal statutes to comply with the PPACA (Sections 54 to 89). (SEE SUMMARY UNDER ACTS PROPOSED BY THE INSURANCE DEPARTMENT)

**EFFECTIVE DATE: Various, see below.**

#### DEFINITIONS (Section 1)

The act defines terms used throughout §§ 1-8. It defines “nonstate public employer” as a municipality or other state political subdivision, including a board of education, quasi-public agency, or public library. A municipality and a board of education may be considered separate employers. A “nonstate public employee” is an employee or elected officer of a nonstate public employer.

A “nonprofit employer” is a (1) nonprofit corporation organized under federal law (26 USC 501) that (a) has a purchase of service contract or (b) receives 50% or more of its gross annual revenue from government grants or funding or (2) tax-exempt labor or agricultural organization under federal law (26 USC 501(c)(5)).

A “partnership plan” is a health care benefit plan offered by the comptroller to nonstate public employers or nonprofit employers under the act.

**EFFECTIVE DATE: July 1, 2011**

#### PARTNERSHIP PLANS (Section 2)

The act requires the comptroller to offer coverage under a partnership plan to certain employer groups that submit an application that is approved under the act's provisions. He must offer coverage to:

1. nonstate public employers and their retirees beginning January 1, 2012 and
2. nonprofit employers and their retirees beginning January 1, 2013.

The act specifies that the comptroller does not have to offer coverage from every partnership plan offered to every employer. It allows the comptroller to offer partnership plans on a fully-insured or risk-pooled basis at his discretion. Any insurer, health maintenance organization (HMO), or entity with which he contracts and any fully insured plan offered is subject to state insurance laws.

#### *Coverage Term, Renewal, and Withdrawal*

In order for an employer group to participate in a partnership plan, the group must agree to benefit periods lasting at least two years. An employer may apply for renewal before the end of each benefit period.

The act requires the comptroller to develop procedures for an employer group to (1) apply to participate in the plan, (2) apply for renewal, and (3) withdraw from participation. The procedures must include the terms and conditions (1) under which a

group can withdraw before the benefit period ends and (2) on how to obtain a refund for any unearned premiums paid or premium equivalent payments made in excess of incurred claims. The procedures must provide that nonstate public employees covered under a collective bargaining agreement must withdraw in accordance with any applicable state collective bargaining laws for municipal employees and teachers.

The act allows the comptroller to collect payments and fees for unreported claims and expenses.

#### *Open Enrollment*

Under the act, initial open enrollment for nonstate public employers must be for coverage that begins July 1, 2012, and subsequent enrollment periods must begin each July 1.

Initial open enrollment for nonprofit employers must be for coverage beginning January 1, 2013. Subsequent enrollment periods must begin each July 1 and January 1.

#### *Application Form*

The act requires the comptroller to create an application for employer groups seeking coverage under a partnership plan and for renewal of such plans. The employer must disclose in the application whether it will offer any other plan to the employees offered the partnership plan.

#### *Taft-Hartley Exception*

The act prohibits an employee from enrolling in a partnership plan if he or she is covered through his or her employer under a health insurance plan or arrangement issued to, or in accordance with, a trust established through collective bargaining under the federal Labor Management Relations Act (i. e. , the Taft-Hartley Act).

#### *Status as a Governmental Health Plan Under Federal ERISA*

The act requires the comptroller to take any necessary actions to ensure that providing coverage to an employer under a partnership plan will not affect the state employee health plan's status as a "governmental plan" under the federal Employee Retirement Income Security Act (ERISA) (see BACKGROUND). ERISA sets certain fiduciary and disclosure standards for private-sector health plans and exempts governmental plans from these requirements.

The act authorizes the comptroller to cancel an employer's coverage with notice and stop accepting applications from nonprofit employers if he determines that providing this coverage affects the state plan's ERISA status. He must create the form and time frame for the cancellation notice.

The comptroller must resume accepting applications from these employers if he determines that granting them coverage will not affect the state employee plan's ERISA status. The act does not set criteria for these decisions.

The comptroller must publicly announce any decision to discontinue or resume (1) coverage or (2) accepting applications under a partnership plan.

#### *Patient-Centered Medical Homes and Claims Data*

The act requires the comptroller to consult with the Health Care Cost Containment Committee (HCCCC) to:

1. develop and implement patient-centered medical homes for the state employee plan and partnership plans that will reduce these plans' costs and
2. review claims data for these plans to target high-cost health care providers and medical conditions and monitor costly trends.

**EFFECTIVE DATE: July 1, 2011**

### EMPLOYER GROUP PARTICIPATION (Section 3)

#### *Permissive and Mandatory Collective Bargaining for Nonstate Public Employers*

The act makes a nonstate public employer group's initial and continuing participation in a partnership plan a permissive subject of collective bargaining. If the union and the employer sign a written agreement to bargain over the participation, then the decision to join the plan is subject to binding arbitration.

#### *Application and Decision Process for All Eligible Employers*

The act establishes two different processes for determining whether a nonstate public or nonprofit employer group's application for coverage will be accepted, depending on whether the application covers all or some of the employees.

If the application covers all employees, the act requires the comptroller to accept the application for the next enrollment period, based on the partnership plan's applicable terms and conditions. The comptroller must give the employer written notice of when coverage begins, pending the employer's acceptance of the plan's terms and conditions. But if the application covers only some employees or it indicates the employer will offer other health plans to employees offered the partnership plan, the comptroller must forward the application to a health care actuary within five days of receiving it.

Within 60 days of receiving an application from the comptroller, the actuary must determine whether it will shift a significant part of the employer group's medical risks to the partnership plan. (The act does not define the term "significant.") If so, the actuary must provide this in writing to the comptroller and include the specific reasons for the decision and the information relied upon in making it.

Under the act, if the comptroller receives a significant risk shift finding from the actuary, he must deny the application and give the employer and HCCCC written notice that includes specific reasons for denial. If the actuary's finding does not indicate such a shift, the comptroller must accept the application and give the employer written notice of when coverage begins, pending the employer's acceptance of the plan's terms and conditions.

The act requires the comptroller to consult with a health care actuary to develop actuarial standards for (1) assessing the shift in medical risks of an employer's employees and retirees to the partnership plan and (2) determining the administrative and fluctuating reserve fees and the premium amounts or premium equivalent payments needed to cover anticipated claims and claim reserves. The comptroller must present the standards to the HCCCC for its review, evaluation, and approval before the standards are used.

(Presumably the comptroller will contract with an actuary for these services although the act does not specify this.)

#### *Exceptions to Actuarial Review*

The act prohibits the comptroller from forwarding to the actuary an application that proposes to cover fewer than all employees because (1) the employer will not cover

temporary, part-time, or durational employees or (2) individual employees decline coverage.

*Regulations Regarding Actuarial Review*

The act authorizes the comptroller to adopt regulations establishing procedures for the reviews and the standards used in them.

**EFFECTIVE DATE: July 1, 2011**

RETIREES (Section 4)

Employer groups whose applications for coverage under a partnership plan are accepted also may seek coverage for their retirees. The act states that Sections one to 14 do not diminish any right to retiree health insurance under a collective bargaining agreement or state law.

The act requires the employer to remit premiums for retirees' coverage to the comptroller in accordance with its provisions.

*Application and Decision Process*

The application process and decision notice requirements with respect to covering an employer's retirees, including actuarial review if the employer proposes to cover fewer than all retirees (even if it covers all employees), is the same as for employees (described in § 3 above).

*Exceptions to Actuarial Review*

The act prohibits the comptroller from forwarding an application to the actuary when the only retirees an employer excludes from the proposed coverage are those who (1) decline coverage or (2) are Medicare enrollees.

**EFFECTIVE DATE: July 1, 2011**

PREMIUMS, FEES, COST SHARING, AND PARTNERSHIP ACCOUNT (Section 5)

*Premiums*

The act requires an employer to pay monthly premiums to the comptroller in an amount he determines for providing coverage for the group's employees and retirees.

It permits an employer to require a covered employee or retiree to pay part of the coverage cost, subject to any applicable collective bargaining agreement.

*Administrative Fee, Fluctuating Reserves Fee, and Employee Contribution*

The act authorizes the comptroller to charge employers an administrative fee calculated on a per member, per month basis. In addition, the comptroller is authorized to charge a fluctuating reserves fee that he deems necessary to ensure an adequate claims reserve. He must do this in accordance with the actuarial standards developed in consultation with the HCCCC.

*Penalties for Late Payment of Premiums/Interest*

If an employer does not pay its premiums by the 10th day after the due date, the act requires the employer to pay interest, retroactive to the due date, at the prevailing rate the comptroller determines.

### *State Money Withheld*

If a nonstate public employer fails to make premium or premium equivalent payments, the act authorizes the comptroller to direct the state treasurer, or any state officer who holds state money (i. e. , grant, allocation, or appropriation) owed the employer, to withhold payment. The money must be withheld until (1) the employer pays the comptroller the past due premiums or premium equivalents and interest or (2) the treasurer or state officer determines that arrangements, satisfactory to the treasurer, have been made for paying the premiums or premium equivalents and interest.

The act prohibits the treasurer or state officer from withholding state money from the group if doing so impedes receiving any federal grant or aid in connection with it.

### *Terminate Plan Participation*

With respect to a (1) nonstate public employer that is not owed state money or from which money is not withheld and (2) nonprofit employer, the act allows the comptroller to terminate the group's participation in the partnership plan for failure to pay premiums or premium equivalents if he gives it at least 10-days' notice. The group can avoid termination by paying premiums or premium equivalents and interest due in full before the termination effective date.

The act allows the comptroller to ask the attorney general to bring an action in Hartford Superior Court to recover any premiums, premium equivalents, and interest owed, or seek equitable relief from a terminated group.

### *Partnership Plan Premium Account*

The act establishes a separate, nonlapsing partnership plan premium account in the General Fund. The comptroller must (1) deposit the premiums collected from employers, employees, and retirees into this account and (2) administer the account to pay claims and administrative fees to entities providing coverage or services under partnership plans.

**EFFECTIVE DATE: July 1, 2011**

## ADVISORY COMMITTEES (Section 6)

### *Nonstate Public Health Care Advisory Committee*

The act establishes a 12-member Nonstate Public Health Care Advisory Committee, which must make recommendations to the HCCCC regarding health care coverage for nonstate public employees.

The committee consists of three representatives each of (1) municipal employers, (2) municipal employees, (3) board of education employers, and (4) board of education employees. Of the three representatives in each category, one must represent each of the following types of towns (1) one with 100,000 or more people, (2) one with at least 20,000 but fewer than 100,000 people, and (3) one with fewer than 20,000 people. The comptroller appoints the committee members.

### *Nonprofit Health Care Advisory Committee*

The act establishes a six-member Nonprofit Health Care Advisory Committee, which must make recommendations to the HCCCC regarding health care coverage for nonprofit employees. The committee consists of three representatives each of (1) nonprofit

employers and (2) nonprofit employees. The comptroller appoints the committee members.

**EFFECTIVE DATE: July 1, 2011**

REGULATIONS (Section 7)

The act authorizes the comptroller to adopt regulations to implement and administer the partnership plans and allows him to implement policies and procedures to administer the plans while adopting the regulations. He must publish notice of intent to adopt the regulations in the *Connecticut Law Journal* within 20 days of implementation. These policies and procedures are valid until the final regulations are adopted.

**EFFECTIVE DATE: July 1, 2011**

SEBAC CONSENT (Section 8)

The act prohibits the comptroller from offering coverage under the partnership plan until (1) the HCCCC provides the comptroller written approval of the act's provisions and (2) the State Employees Bargaining Agents Coalition (SEBAC) provides the House and Senate clerks written consent to incorporate the act's terms into its collective bargaining agreement. (Presumably, SEBAC's written consent goes to the clerks for legislative action. By law, if the legislature does not act within 30 days, the agreement is deemed approved (CGS § 5-278(b)). )

It specifies that nothing in the act's partnership plan provisions modifies the state employee health plan without the written consent of SEBAC and the Office of Policy and Management (OPM) secretary.

**EFFECTIVE DATE: Upon passage**

MUNICIPAL HEALTH PLANS (Section 9)

By October 1, 2011, and annually thereafter, the act requires municipal employers of more than 50 people to electronically submit to the comptroller, in a form he prescribes, information for any fully-insured group health plan they sponsor for active employees or retirees covering (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; (4) hospital or medical services, including coverage under an HMO plan; and (5) single-service ancillary health coverage plans, including dental, vision, and prescription drug plans.

The required information is the percentage increase or decrease in group health insurance policy or plan costs in the immediately preceding two policy years. To calculate the percentage change, the employer must divide the total premium costs, including any premiums or contributions the employees or retirees paid, by the total number of covered employees and retirees.

Under the act, the covered employers are towns; cities; boroughs; and school, taxing, and fire districts.

**EFFECTIVE DATE: July 1, 2011**

HEALTH INSURANCE CLAIMS DATA (Section 10)

By law, insurers, health care centers (i.e., HMOs), hospital or medical service corporations, or other entities that deliver, issue, renew, amend, or continue 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, must provide, at the request of a municipal employer with more than 50 employees sponsoring the policy:

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 categories.

The act extends the requirement to insurers and entities that deliver, issue, renew, amend, or continue any group health insurance policy covering single-service ancillary health coverage plans, including dental, vision, and prescription drug plans. It requires all the insurers and entities to provide this and the other information free of charge by October 1 annually.

By law, the information provided (1) can be used only to get competitive quotes for group health insurance or promote employees wellness initiatives and (2) is confidential and not subject to disclosure under the Freedom of Information Act (FOIA). The act allows employers to give the information to the comptroller upon request. The comptroller must keep it confidential.

**EFFECTIVE DATE: July 1, 2011**

## OCHA DATA COLLECTION (Section 12)

### *Hospital Data*

By law, hospitals must provide the Office of Health Care Access (OHCA) division of the Department of Public Health (DPH) with hospital discharge and patient billing data. Prior law required OHCA to keep individual patient and billing data confidential, but permitted it to disclose aggregate reports from which individual patient and physician data cannot be identified.

The act instead requires hospitals to submit patient-identifiable inpatient discharge data and emergency department data to OHCA. "Patient-identifiable data" means any information that identifies, or may reasonably be used as a basis to identify, an individual patient, including data from patient medical abstracts and bills.

The act allows an intermediary to submit data to OHCA on behalf of a hospital or outpatient surgical facility. (PA 11-61, § 143 instead allows the data to be submitted through a contractual arrangement with an intermediary. The contractual arrangement must (1) comply with federal Health Insurance Portability and Accountability Act (HIPAA) and (2) ensure that data is submitted accurately and timely.)

### *Outpatient Data*

The act also requires outpatient surgical facilities, hospitals, or facilities providing outpatient surgical services as part of a hospital's outpatient surgery department to provide OHCA with the following: (1) the facility's name, location, and operating hours; (2) the type of facility and services provided; and (3) the total number of clients, treatments, patient visits, and procedures or scans performed in a calendar year.

The act requires OHCA to convene a working group of representatives of outpatient surgical facilities, hospitals and other individuals necessary to develop recommendations addressing current obstacles to and proposed requirements for patient-identifiable data reporting in the outpatient setting. By February 1, 2012, the working group must report its findings and recommendations to the Public Health and Insurance and Real Estate committees.

The office must begin reporting additional outpatient data it deems necessary by July 1, 2015. By July 1, 2012, and annually thereafter, the Connecticut Association of Ambulatory Surgery Centers must provide a progress report to DPH, until all ambulatory surgery centers comply with the implementation of systems that allow for reporting of outpatient data required by DPH. Until such additional reporting requirements take effect, DPH may work with the Connecticut Association of Ambulatory Surgery Centers and the Connecticut Hospital Association on specific data reporting initiatives. But the act specifies that DPH cannot assess penalties for failing to submit the data.

#### *Data Confidentiality*

Under the act, patient-identifiable data OHCA receives must be kept confidential and is not considered a public record or file subject to disclosure under FOIA. OHCA may release de-identified patient data or aggregate patient data to the public in a manner consistent with the federal Health Insurance Portability and Accountability Act's (HIPAA) privacy provisions. The act defines "de-identified patient data" as any information that meets the requirements for de-identification of protected health information under HIPAA. Any de-identified patient data released by OHCA must exclude provider, physician and payer organization names or codes and be kept confidential by the recipient. OHCA may not release patient-identifiable data except for medical and scientific research purposes as provided under current law (CGS § 19a-25) and regulations. The act prohibits an individual or entity that receives patient-identifiable data from releasing it in any manner that may result in the identification of an individual patient, physician, provider, or payer. OHCA must impose a reasonable, cost-based fee for any patient data provided to a nongovernmental entity.

The act requires OCHA, by October 1, 2011, to enter into a memorandum of understanding with the comptroller to allow him access to this data if he agrees in writing to keep confidential individual patient and physician data identified by name or personal identification code. (PA 11-61, § 143 instead requires the comptroller to keep patient and provider data confidential.)

The DPH commissioner must adopt regulations to carry out these provisions, which must be implemented within available appropriations.

**EFFECTIVE DATE: July 1, 2011**

#### OFFICE OF HEALTH CARE REFORM AND INNOVATION (Section 11 and 13)

The act establishes the Office of Health Reform and Innovation (OHRI) within the Office of the Lieutenant Governor. The special advisor to the governor on healthcare reform must direct its activities.

OHRI must:

1. coordinate and implement the state's responsibilities under state and federal health care reform;

2. identify (a) federal grants and other nonstate funding sources to help implement the PPACA and (b) other measures that enhance health care access, reduce costs, and improve the quality of the state's health care;
3. recommend and advance executive action and legislation to effectively and efficiently implement the PPACA and state health care reform initiatives;
4. design processes to maximize stakeholder and public input and ensure transparency in implementing health care reform;
5. ensure information sharing and coordination of efforts with the General Assembly and state agencies concerning public health and health care reform;
6. report on or after January 1, 2012, and annually thereafter, to the Appropriations, Human Services, Insurance and Real Estate, and Public Health committees on state agencies' progress in implementing the PPACA;
7. ensure coordination of efforts with state agencies on the prevention and management of chronic illnesses;
8. ensure state government structures are working together to effectively implement federal and state health care reform;
9. ensure, in consultation with the Connecticut Health Insurance Exchange and Department of Social Services, necessary coordination between the exchange and Medicaid enrollment planning and coordinated efforts among state agencies in order to prevent and manage chronic illnesses; and
10. maximize private philanthropic support to advance health care reform initiatives.

By August 1, 2011, OHRI must consult with the Sustinet Health Care Cabinet established under the act (see § 14) and convene a consumer advisory board with at least seven members.

OHRI and the Office of the Healthcare Advocate must provide staff support to the cabinet. OHRI must maintain a central comprehensive health reform web site. The act directs state agencies to use their best efforts to assist OHRI, within available appropriations.

OHRI, in consultation with the Sustinet Health Care Cabinet, may use any consultants necessary to carry out its statutory responsibilities. The office may retain consultants to conduct feasibility and risk assessments required to implement, as may be practicable, private and public mechanisms to provide adequate health insurance products to individuals, small employers, nonstate public employers, municipal-related employers, and nonprofit employers, beginning on January 1, 2014. Not later than October 1, 2012, OHRI and the cabinet must make recommendations to the governor based on the results of analyses.

#### *Multipayer Data Initiative*

Under the act, OHRI must convene a working group to develop a plan implementing a state-wide multipayer data initiative to improve the state's use of health care data from multiple sources to increase efficiency, enhance outcomes, and improve the understanding of health care expenditures in the public and private sectors. The group must include the OPM secretary; comptroller; the commissioners of public health, social services, and insurance; health care providers; representatives of health insurance companies; health insurance purchasers; hospitals; and consumer advocates.

OHRI must report on the initiative plan to the Appropriations, Insurance and Real Estate, and Public Health committees.

**EFFECTIVE DATE: Upon passage**

SUSTINET HEALTH CARE CABINET (Section 14)

The act establishes, within the Office of the Lieutenant Governor, the SustiNet Health Care Cabinet to advise the governor and OHRI on issues specified.

*Members and Appointment Process*

The 28-member cabinet consists of the following members who must be appointed by August 1, 2011:

1. five appointed by the governor, (a) two representing the health care industry serving four-year terms, (b) one representing community health centers serving three years, (c) one representing insurance producers serving three years, and (d) one at-large appointment and serving three years;
2. one appointed by the Senate president pro tempore who is an oral health specialist engaged in active practice serving four years;
3. one appointed by the Senate majority leader, representing labor and serving three years;
4. one appointed by the Senate minority leader who is an advanced practice registered nurse engaged in active practice and serving two years;
5. one consumer advocate appointed by the House speaker serving four years;
6. one appointed by the House majority leader who is a primary care physician engaged in active practice serving four years;
7. one appointed by the House minority leader representing the health information technology industry and serving three years;
8. five appointed jointly by the chairpersons of the SustiNet Health Partnership board of directors, one each representing faith communities, small businesses, the home health care industry, hospitals, and an at-large appointment, all of whom serve five-year terms;
9. the lieutenant governor;
10. the OPM secretary, the comptroller, the healthcare advocate and the special advisor to the governor on healthcare reform or their designees; the commissioners of Social Services and Public Health, or their designees; all of whom serve as ex-officio voting members; and
11. the commissioners of Children and Families, Developmental Services, Mental Health and Addiction Services, and Insurance or their designees, and the nonprofit liaison to the governor, or his designee, all of whom serve as ex-officio nonvoting members.

Subsequent cabinet terms begin on August 1 of the year appointed and last for four years. If an appointing authority does not make an appointment initially or within 90 days of a vacancy, the cabinet must appoint a member by majority vote.

When the initial terms of the five cabinet members appointed by the SustiNet Health Partnership board of directors expire, five successor cabinet members must be appointed as follows: (1) one appointed by the governor; (2) one appointed by the Senate president pro tempore; (3) one appointed by the House speaker; and (4) two appointed by majority board vote. These successor board members are at-large appointments.

The lieutenant governor serves as the cabinet chairperson; the cabinet must hold its first meeting by September 1, 2011.

#### *Cabinet Duties*

The cabinet must advise the governor and OHRI on developing an integrated health care system for Connecticut and must:

1. evaluate the means of ensuring an adequate health care workforce in the state;
2. jointly evaluate, with the chief executive officer of the Connecticut Health Insurance Exchange, the feasibility of implementing a basic health program option allowed under the PPACA;
3. identify short- and long-range opportunities, issues, and gaps created by the enactment of the PPACA;
4. coordinate with OHRI concerning the effectiveness of delivery system reforms and other efforts to control health care costs, including reforms and efforts implemented by state agencies;
5. develop a business plan for the governor and OHRI that takes into account the OHRI feasibility and risk assessments (see § 13) and evaluates private or public mechanisms that will provide adequate health insurance products beginning on January 1, 2014, including for-and non-profit organizations, insurance cooperatives, and self-insurance and (b) submit appropriate implementation recommendations to the governor.
6. advise the governor on the (a) design, implementation, actionable objectives, and evaluation of state and federal health care policies, priorities, and objectives relating to the state's efforts to improve health care access and (b) quality of such care and the affordability and sustainability of the state's health care system.

The cabinet may convene working groups, which can include volunteer health care experts, to make recommendations on developing and implementing service delivery and health care provider payment reforms, including multi-payer initiatives, medical homes, electronic health records, and evidenced-based health care quality improvement.

**EFFECTIVE DATE: Upon passage**

#### CLAIM PAYMENT REQUIREMENTS (Section 15)

Prior law required health insurers to pay claims within 45 days of receiving them. The act increases the time an insurer has to pay claims submitted on paper and decreases the time it has to pay claims submitted electronically.

#### *Paper Claims*

The act requires insurers to pay paper claims within 60 days of receiving them. As under existing law, if the claim does not include all required information, the insurer must send written notice to the claimant requesting the information be sent within 30 days. Upon receiving the requested information, the insurer must pay the claim within 30 days.

#### *Electronic Claims*

The act requires insurers to pay electronic claims within 20 days of receiving them. If the claim does not include all required information, the insurer must send written notice to the claimant requesting the information be sent within 10 days. Upon receiving the requested information, the insurer must pay the claim within 10 days.

### *Claims Paid Late*

By law, if an insurer fails to pay a claim on time, it must pay the claimant the amount of the claim plus 15% interest. This is in addition to any other penalties imposed by law. If the interest due is less than \$1, the insurer must instead deposit the amount in a separate interest-bearing account. At the end of each calendar year, the insurer must donate the

account funds to the UConn Health Center.

**EFFECTIVE DATE: January 1, 2012**

### NEW INSURANCE PRODUCTS (Section 16)

The act permits a contracting health organization (e. g. , insurer or HMO) to introduce new insurance products to health care providers at any time as long as it gives the provider at least 60 days advance notice if the new product makes material changes to the administrative requirements or fee schedule portions of the provider's contract. The advance notice must allow the provider at least 30 days to decide whether to participate in the new insurance product. The provider may decline participation.

**EFFECTIVE DATE: January 1, 2012**

### PROVIDER NETWORK ADEQUACY (Section 17)

The act requires each insurer that contracts with licensed health care providers to maintain a provider network that is consistent with the National Committee for Quality Assurance's (NCQA's) network adequacy requirements or URAC's provider network access and availability standards.

For purposes of this section, insurers include HMOs, managed care organizations (MCOs), preferred provider networks, and other entities that deliver, issue, renew, amend, or continue individual or group health insurance policies or medical benefits plans.

NCQA and URAC are nonprofit organizations that accredit and certify a wide range of health care organizations. (URAC was previously known as the Utilization Review Accreditation Commission.)

**EFFECTIVE DATE: January 1, 2012**

### PRIOR AUTHORIZATIONS (Section 18)

The act prohibits insurers and utilization review companies that grant prior authorizations for admissions, services, procedures, or extensions of hospital stays on or after January 1, 2012 from reversing or rescinding the authorization or refusing to pay for the admission, service, procedure, or extension of stay if:

1. the insurer or company did not notify the health care provider at least three business days before the scheduled date of the admission, service, procedure, or extension of stay that it was reversed or rescinded due to medical necessity, fraud, or lack of coverage and
2. the admission, service, procedure, or extension of stay took place in reliance on the prior authorizations.

The act specifies that this applies regardless of whether the preauthorization is required or requested by an insured's health care provider. It also specifies that a preauthorization is effective for at least 60 days from when it is issued, unless it is reversed or rescinded.

These provisions are not to be construed as authorizing benefits or services in excess of those provided for in the policy or contract.

For purposes of this section, insurers include HMOs, fraternal benefit societies, hospital and medical service corporations, and other entities that deliver, issue, renew, amend, or continue individual or group health insurance policies or medical benefit plans in

Connecticut that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, or (4) hospital or medical services.

**EFFECTIVE DATE: January 1, 2012**

#### DENTIST CHARGES (Section 19)

Under the act, a provider contract between an insurer and a licensed dentist entered into, renewed, or amended on or after January 1, 2012 cannot require the dentist to accept as payment an amount the insurer sets for services or procedures that are not covered benefits under the dental plan.

The act prohibits a dentist from charging more than his or her usual and customary rate for such noncovered services or procedures.

It requires each evidence of coverage for an individual or group dental plan to include the following statement:

“IMPORTANT: If you opt to receive dental services or procedures that are not covered benefits under this plan, a participating dental provider may charge you his or her usual and customary rate for such services or procedures. Prior to providing you with dental services or procedures that are not covered benefits, the dental provider should provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your evidence of coverage document.”

The act requires dentists to post, in a conspicuous place, a notice stating that services or procedures that are not covered benefits under an insurance policy or plan might not be offered at a discounted rate.

For purposes of this section, an insurer includes an HMO, fraternal benefit society, hospital or medical service corporation, or other entity that delivers, issues, renews, amends, or continues an individual or group dental plan in Connecticut.

This section does not apply to a self-insured plan or collectively bargained agreement.

**EFFECTIVE DATE: January 1, 2012**

#### **Sections 20 to 36 related to Third Party Administrators is summarized under Acts Proposed by the Insurance Department**

#### DEPENDENTS COVERED TO AGE 26 (Section 37 to 40)

Under PPACA, children may stay on a parent's health insurance plan until age 26. The act revises various insurance statutes to comply with this requirement. Prior state law restricted a child's coverage based on his or her marriage or residency status.

**EFFECTIVE DATE: Upon passage**

#### PREEXISTING CONDITIONS (Sections 41 and 46)

Under PPACA, insurers cannot impose a preexisting condition limitation that excludes coverage for children under age 19. The act revises various insurance statutes to comply with this requirement. It specifies that no insurer can refuse to issue an individual health

insurance plan to a child under age 19 solely on the basis that the child has a preexisting condition.

**EFFECTIVE DATE: Upon passage**

#### LIFETIME LIMITS (Sections 42 and 43)

Under PPACA, health benefit plans cannot impose lifetime limits on the dollar value of “essential health benefits,” to be defined by the U. S. Department of Health and Human Services. To conform to the federal requirement, the act prohibits individual and group comprehensive health care plans from imposing such a lifetime limit. It specifies that a plan may include a lifetime limit of at least \$1 million on benefits that are not essential health care benefits as defined by PPACA and related regulations.

**EFFECTIVE DATE: Upon passage**

#### CONTINUATION OF COVERAGE (Sections 44 and 45)

As under prior law, the act requires health insurers to provide continuation of coverage to individuals under specified circumstances.

**EFFECTIVE DATE: Upon passage**

#### RESCISSIONS (Sections 47 and 48)

PPACA limits policy rescissions (e. g. , retrospective policy cancellations) to instances of fraud and intentional material misrepresentation.

Under state law, an insurer or HMO must obtain the insurance commissioner's approval for a policy rescission, cancellation, or limitation. The act requires the commissioner to approve a request for rescission or limitation when the insured or the insured's representative (1) submitted fraudulent (rather than false) information on an insurance application, (2) intentionally (rather than knowingly) misrepresented material information on the application, or (3) intentionally (rather than knowingly) omitted material information from the application. He must approve a cancellation in accordance with federal law, which requires prior notice to the insured.

**EFFECTIVE DATE: Upon passage**

#### MEDICAL LOSS RATIO (Sections 49 to 52)

The Insurance Department publishes an annual Consumer Report Card on Health Insurance Carriers in Connecticut. By law, the report card must include each insurer's and HMO's medical loss ratio. The act refers to that medical loss ratio as the “state medical loss ratio” and specifies that the report card also include the federal medical loss ratio, as defined in PPACA. “Medical loss ratio” is generally the percentage of premium dollars that an insurer or HMO spends on providing health care and health care quality improvement activities, compared to how much is spent on administrative and overhead costs.

By law, an insurer or HMO must include a written notice with each application for individual or group health insurance coverage that discloses the medical loss ratio. The act requires disclosure of both the state and federal medical loss ratios.

The act requires a managed care organization to report both medical loss ratios to (1) the insurance commissioner and (2) enrollees.

**EFFECTIVE DATE: January 1, 2012**

**Section 53 related to Patient Protection and Affordable Care Act Compliance and Regulations is summarized under Acts Proposed by the Insurance Department**

**Sections 54 to 89 related to Utilization Review, Grievance and External Review processes is summarized under Acts Proposed by the Insurance Department**

**REPEALED SECTIONS (Section 90)**

The act repeals the prior SustiNet law.

**EFFECTIVE DATE: September 1, 2011**

**Public Act 11-67 (Senate Bill 10); Also see Public Act 11-171 for related provisions  
An Act Concerning Insurance Coverage for Breast Magnetic Resonance Imaging  
and Permitting Districts to Join Municipalities and Boards of Education to Procure  
Health Care Benefits  
(Signed by Governor 7/8/2011)**

This act requires certain health insurance policies to cover magnetic resonance imaging (MRI) of a woman's entire breast or breasts in specified circumstances.

The law 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 specified conditions. The act extends this power to special taxing districts, allowing them to enter into such agreements with other districts, municipalities, and boards of education, or any combination of these entities. By law, "district" includes a fire, sewer, or fire and sewer district; lighting district; village, beach, or improvement association; and any other district or association, except a school district, wholly within a town and having the power to make appropriations or levy taxes.

**EFFECTIVE DATE: October 1, 2011, except for the provisions requiring insurance coverage for breast MRI, which are effective January 1, 2012.**

**COVERAGE FOR BREAST MRI**

The act requires certain health insurance policies to cover MRIs of a woman's entire breast or breasts if (1) a mammogram shows heterogeneous or dense breast tissue based on the American College of Radiology's Breast Imaging Reporting and Database System (BI-RADS) or (2) a woman is considered at an increased breast cancer risk because of

family history, her own breast cancer history, positive genetic testing, or other indications determined by her physician or advanced-practice registered nurse. By law, policies must cover (1) breast ultrasounds under the same specified circumstances, (2) a baseline mammogram for a woman age 35 to 39, and (3) a yearly mammogram for a woman age 40 or older.

The act applies to individual and group health insurance policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including those provided by HMOs. It removes an erroneous reference to accident-only policies. (Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.)

## BACKGROUND

### *Related Act*

PA 11-171 requires certain health insurance policies to cover MRIs of a woman's breasts in accordance with guidelines established by the American Cancer Society or the American College of Radiology.

### *Related Law*

State law limits the copayments for MRIs to \$75 for one and \$375 for all MRIs annually (CGS §§ 38a-511 and 38a-550). The limit does not apply (1) if the physician ordering the imaging service performs it or is in the same practice group as the physician who performs it and (2) to high deductible health plans designed to be compatible with federally qualified health savings accounts.

### *BI-RADS Categories*

The American College of Radiology collaborated with the National Cancer Institute, the Centers for Disease Control and Prevention, the American Medical Association, and others to develop BI-RADS, which is used to standardize mammography reporting. There are two BI-RADS scales: one characterizes breast density and the other characterizes a radiologist's reading of what he or she sees on a mammogram.

## **Public Act 11-83 (Senate Bill 923)**

### **An Act Concerning the American College of Radiology and Colorectal Cancer Screening Recommendations and Health Insurance Coverage for Colonoscopies (Signed by the Governor 7/8/2011)**

By law, certain health insurance policies must cover colorectal cancer screening, including (1) an annual fecal occult blood test and (2) colonoscopy, flexible sigmoidoscopy, or radiologic imaging, in accordance with American College of Gastroenterology (ACOG) recommendations regarding age, family history, and test frequency. This act requires ACOG to consult with the American College of Radiology, not just the American Cancer Society, when making screening recommendations.

The act also prohibits these insurance policies from imposing a coinsurance, copayment, deductible, or other out-of-pocket expense for any additional colonoscopy a physician orders for an insured person in a policy year. Other than this prohibition, benefits are subject to the same terms and conditions that apply to policy benefits. The act's prohibition does not apply to a high-deductible health plan designed to be compatible with federally qualified health savings accounts.

The individual and group health insurance policies covered by the act are those delivered, issued, amended, renewed, 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 the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured plans.

**EFFECTIVE DATE: January 1, 2012**

**Public Act 11-88 (House Bill 5032)**

**An Act Requiring Health Insurance Coverage for Bone Marrow Testing**

**(Signed by the Governor 7/8/2011)**

This act requires certain health insurance policies to cover compatibility testing for bone marrow transplants (known as human leukocyte antigen testing and also referred to as histocompatibility locus antigen testing) for A, B, and DR antigens. Under the act, a policy (1) may limit coverage to one test in a person's lifetime and (2) cannot impose a coinsurance, copayment, deductible, or other out-of-pocket expense for testing that exceeds 20% of the cost for testing per year, unless it is a high-deductible policy designed to be compatible with federally qualified health savings accounts.

The act requires a policy to (1) require bone marrow testing at a facility certified under the federal Clinical Laboratory Improvement Act and accredited by the American Society for Histocompatibility and Immunogenetics or its successor and (2) limit coverage to people who sign up for the National Marrow Donor Program when being tested.

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; and (4) hospital or medical services, including coverage under an HMO plan.

Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

**EFFECTIVE DATE: January 1, 2012**

## BACKGROUND

### *Clinical Laboratory Improvement Act*

The federal Centers for Medicare and Medicaid Services regulate all laboratory testing (except research) performed on people in the United States under the Clinical Laboratory Improvement Act.

### *American Society for Histocompatibility and Immunogenetics*

This society is a nonprofit association of clinical and research professionals, including immunologists, geneticists, transplant physicians and surgeons, and pathologists. It is a member of the United Network for Organ Sharing and works with numerous scientific and medical organizations, including the National Marrow Donor Program. It develops and maintains accreditation standards for laboratories.

## **Public Act 11-132 (House Bill 6471)**

### **An Act Concerning Most Favored Nation Clauses in Health Care Provider Contracts**

**(Signed by the Governor 7/8/2011)**

This act prohibits a contracting health organization (i.e., managed care organization (MCO) or preferred provider network (PPN)) from including a “most favored nation” (MFN) clause in a contract with a health care provider, dentist, or hospital.

Specifically, it prohibits these contracts from including any provision that prohibits a provider, dentist, or hospital from contracting with another MCO or PPN at a lower payment or reimbursement rate. It also prohibits these contracts from (1) containing provisions requiring a provider, dentist, or hospital to disclose the payment or reimbursement rates of another MCO or PPN with which it contracts or (2) being renegotiated before renewal if a lower payment or reimbursement rate is agreed to between the provider, dentist, or hospital and another MCO or PPN.

The act applies to contracts entered into, renewed, amended, or offered on or after October 1, 2011. Contracts in effect prior to this date that include an MFN clause are void and unenforceable on the contract renewal date or January 1, 2014, whichever is earlier. The act specifies that its provisions do not affect the contracting health organization's rights to enforce the MFN clause before its invalidation.

By law, “providers” include Connecticut-licensed physicians, surgeons, chiropractors, podiatrists, psychologists, optometrists, naturopaths, and advanced practice registered nurses.

**EFFECTIVE DATE: October 1, 2011**

## CONTRACT PROVISIONS

The act prohibits a contracting health organization from including in any contract with a provider, dentist, or hospital, any clause, covenant, or agreement that:

1. requires the hospital, dentist, or provider to (a) disclose to the organization its payment or reimbursement rates from any other organization it contracts or may contract with; (b) provide services or procedures to the organization at a payment or reimbursement rate equal to or lower than the lowest rate at which the provider, dentist, or hospital contracts or may contract with another organization; or (c) certify to the organization that the provider, dentist, or hospital has not contracted with any other organization to provide services or procedures at a lower payment or reimbursement rate;
2. prohibits or limits the provider, dentist, or hospital from contracting with any other organization to provide services or procedures at a lower payment or reimbursement rate;
3. allows the organization to terminate or renegotiate a contract with a provider, dentist, or hospital prior to renewal if the provider, dentist, or hospital contracts with another organization to provide services or procedures at a lower payment or reimbursement rate.

## BACKGROUND

### *Most Favored Nation Clauses*

A “most favored nation clause” is a provision in a contract between a health care provider and an insurer that prohibits the provider from charging the insurer a rate that is higher than the lowest reimbursement rate the provider accepts from any other insurer.

## **Public Act 11-163 (Senate Bill 314)**

### **An Act Concerning Mental or Nervous Conditions Under the Connecticut Unfair Insurance Practices Act**

**(Signed by the Governor 7/13/2011)**

This act adds to the list of unfair or deceptive insurance acts or practices, the (1) refusal to insure or continue to insure; (2) limitation of the amount, extent, or kind of coverage available to; or (3) charging of a different rate for the same coverage to, an individual diagnosed with a mental or nervous condition. The law already prohibits such acts or practices for individuals with a physical disability or mental retardation.

The law allows such a refusal, limitation, or rate differential if it is (1) based on sound actuarial principles or (2) related to actual or reasonably anticipated experience.

The act defines “mental or nervous conditions” as mental disorders as it is used in the American Psychiatric Association's most recent *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR fourth edition, text revision). It specifically excludes (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.

**EFFECTIVE DATE: October 1, 2011**

## BACKGROUND

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

CUIPA prohibits engaging in unfair or deceptive insurance acts or practices. It 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 instead of a license suspension or revocation, for violating a cease and desist order.

### **Public Act 11-169 (Senate Bill 1083)**

#### **An Act Concerning Health Insurance Coverage of Prescription Drugs for Pain Treatment**

**(Signed by the Governor 7/13/2011)**

This act prohibits certain health insurance policies that provide prescription drug coverage from requiring an insured to use an alternative brand name prescription drug or over-the-counter drug before using a brand name prescription drug prescribed by a licensed physician for pain treatment. But, it allows these policies to require an insured to first use a therapeutically equivalent generic drug.

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; (4) hospital or medical services, including coverage under an HMO plan; and (5) limited benefits.

Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

**EFFECTIVE DATE: January 1, 2012**

### **Public Act 11-171 (Senate Bill 18); Also see Public Act 11-67 for related provisions**

#### **An Act Concerning Insurance Coverage for Breast Magnetic Resonance Imaging and Extending the Notification Period to Insurers Following the Birth of a Child**

**(Signed by the Governor 7/13/2011)**

This act requires certain health insurance policies to cover magnetic resonance imaging (MRI) of a woman's breasts in accordance with guidelines established by the American Cancer Society or the American College of Radiology. By law, policies must cover (1) breast ultrasounds under specified circumstances, (2) a baseline mammogram for a woman age 35 to 39, and (3) a yearly mammogram for a woman age 40 and older.

By law, policies that cover family members must cover injury and sickness, including care and treatment of congenital defects and birth abnormalities, for newborns from birth. The act extends, from 31 to 61 days after the birth, the time within which an insurer, HMO, or hospital or medical service corporation must be notified of the birth and paid any required premium or subscription fee. The act specifies that if such notification and payment is not received within 61 days (1) it does not prejudice claims originating during that period and (2) the newborn's coverage ends.

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; and (4) hospital or medical services, including those provided by HMOs. The newborn coverage requirement also applies to accident-only policies.

Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

**EFFECTIVE DATE: January 1, 2012**

## BACKGROUND

### *Related Act*

PA 11-67 requires certain health insurance policies to cover magnetic resonance imaging (MRI) of a woman's entire breast or breasts in specified circumstances.

## **Public Act 11-172 (Senate Bill 21)**

### **An Act Concerning Health Insurance Coverage for Routine Patient Care Costs for Certain Clinical Trial Patients**

**(Signed by the Governor 7/13/2011)**

By law, individual and group health insurance policies and HMO contracts must cover (1) medically necessary hospitalization services and other routine patient care costs associated with cancer clinical trials and (2) off-label cancer prescription drugs. This act expands the coverage requirements to include all disabling or life-threatening chronic diseases rather than cancer only. (The act does not define these terms.)

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; and (4) hospital or medical services, including coverage under an HMO plan. Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

The act also makes technical and conforming changes.

**EFFECTIVE DATE: January 1, 2012**

## CLINICAL TRIALS

The act defines a “clinical trial” as an organized, systemic, scientific study of interventions for the treatment of cancer or disabling or life-threatening chronic diseases, or therapeutic intervention for prevention.

The act removes the requirement under prior law that a clinical trial for cancer prevention must be a Phase III trial conducted at multiple institutions. (Phase III clinical trials compare a new drug or surgical procedure to the current standard of treatment.) The act does not require a Phase III trial for other types of preventive clinical trials it covers.

### *Eligibility for Coverage*

By law, to be eligible for coverage, a cancer clinical trial must be conducted under an independent, peer-reviewed protocol approved by one of the National Institutes of Health, a National Cancer Institute-affiliated cooperative group, the federal Food and Drug Administration (FDA) as part of an investigational new drug or device exemption, or the U. S. departments of Defense or Veterans' Affairs. The act applies this requirement to clinical trials for disabling or life-threatening chronic diseases. It also makes eligible for coverage clinical trials for disabling or life-threatening chronic diseases that qualify for Medicare coverage under the Medicare Clinical Trials Policy established under the September 19, 2000 Medicare National Coverage Determination. The act also expands coverage to include FDA-approved protocols that are part of an investigational new drug or device application, instead of only a drug or device exemption.

The insurer, HMO, or plan administrator may require the person or entity seeking coverage for the clinical trial to provide:

1. evidence that the patient meets all selection criteria for the clinical trial, including credible clinical evidence showing the clinical trial is likely to benefit the person compared to the risks of participation;
2. evidence that the patient has given his or her informed consent;
3. copies of medical records, protocols, test results, or other clinical information used to enroll the patient in the clinical trial;
4. a summary of the anticipated routine patient costs in excess of the standard treatment costs;
5. information regarding items eligible for reimbursement from other sources, including the entity sponsoring the clinical trial; and
6. additional information reasonably required to review the coverage request.

This is already law for cancer clinical trials.

### *Routine Patient Care Costs*

By law, and extended to all clinical trials by the act, “routine patient care costs” are (1) medically necessary health care services, including physician services, diagnostic or laboratory tests, and hospitalization, incurred as a result of the treatment being provided that would otherwise be covered if they were not rendered as part of a clinical trial and (2) costs incurred for federal FDA-approved drugs. The services must be consistent with the usual and customary standard of care.

Hospitalization must include treatment at an out-of-network facility if such treatment is not available in-network and is not eligible for reimbursement by the clinical trial.

Routine patient care costs must be subject to the terms, conditions, restrictions, exclusions, and limitations of the insurance contract or certificate, including limitations on out-of-network care. But treatment at an out-of-network hospital must be made available by the out-of-network hospital and the insurer or HMO at no greater cost to the insured person than if such treatment was available in-network. The insurer or HMO may require that any routine tests or services required under the clinical trial be performed by contracted providers.

Routine patient care costs do not include:

1. the cost of an investigational new drug or device that is not FDA-approved;
2. the cost of a non-health-care service that an insured person may be required to receive as a result of the clinical trial;
3. facility, ancillary, professional services, and drug costs that are paid for by grants or funding for the clinical trial;
4. costs of services that are (a) inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or (b) performed specifically to meet the requirements of the clinical trials;
5. costs that would not be covered under the insured person's policy for non-investigational treatments, including items excluded from coverage under the person's insurance contract; and
6. transportation, lodging, food, or any other expenses associated with travel to or from the clinical trial facility.

Health care providers, including hospitals and institutions, that provide routine patient care services approved for coverage cannot bill the insurer, HMO, or insured for any (1) services or costs that do not meet the definition of routine patient care services or (2) product or service for which the clinical trial sponsor is paying.

#### *Payment to Out-of-Network Providers*

An insurer or HMO must pay out-of-network providers the lesser of (1) the lowest contracted daily fee schedule or case rate it pays its Connecticut in-network providers for similar services or (2) actual charges. Out-of-network providers may not collect more than the total amount paid by the insurer or HMO and the insured's deductible and copayment.

#### *Coverage Request Form*

The act requires the Insurance Department to develop a standardized form that all providers must submit to the insurer or HMO when seeking to enroll an insured patient in a clinical trial for disabling or life-threatening chronic diseases, excluding cancer. (The law already requires this for cancer trials.) The department must develop the form in consultation with:

1. at least one state nonprofit research or advocacy organization related to the clinical trial's subject,

2. at least one national nonprofit research or advocacy organization related to the clinical trial's subject,
3. the Connecticut Association of Health Plans, and
4. Anthem Blue Cross of Connecticut.

An insurer or HMO must use the department's form unless it is exempt because its coverage is certified to be substantially the same as the act requires and it has the department's approval to use another form.

An insurer or HMO that receives a completed form from a provider requesting coverage for routine patient care costs for clinical trials must approve or deny the request within five business days or, if using independent experts to review clinical trial requests, 10 business days. The act removes the requirement under current law that requests for coverage of Phase III cancer prevention clinical trials be approved or denied within 14 business days.

Under existing law, the Insurance Department has to (1) develop a form for use with cancer clinical trials and (2) adopt regulations to implement the coverage request form requirements, which the act extends to other clinical trials.

#### *Exemption from Requirements*

Insurers and HMOs must submit their coverage policies for clinical trials to the Insurance Department for evaluation and approval. The department must certify whether the coverage policy is substantially equivalent to the act's requirements. If it is, the insurer or HMO is exempt from the act's requirements.

An exempt insurer or HMO must annually report in writing to the department that there have been no changes to the coverage policy. If there have been changes, the insurer or HMO must resubmit the policy for the department's certification.

#### OFF-LABEL DRUGS

By law, individual and group health insurance policies that cover a prescription drug that is FDA-approved to treat a certain type of cancer must also cover the drug when it is used for another type of cancer (known as "off-label" drugs) if it is recognized as a cancer treatment in one of three sources.

The act requires coverage for off-label drug use for FDA-approved drugs to treat disabling or life-threatening chronic diseases. The drug must be recognized for the treatment of such a condition in the:

1. U. S. Pharmacopoeia Drug Information Guide for the Health Care Professional,
2. American Medical Association's Drug Evaluations, or
3. American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information.

The act specifies that it does not require coverage for experimental or investigational drugs or any drug that the FDA has determined to be contraindicated for the treatment of a specific disabling, or life-threatening chronic disease. This is already law with respect to cancer drugs.

**Public Act 11-199 (House Bill 6306)**  
**An Act Concerning the Listing of Advanced Practice Registered Nurses in Managed Care Organization Provider Listings, and Primary Care Provider Designations**  
**(Signed by the Governor 7/13/2011)**

By law, managed care organizations (MCOs) must annually provide health plan enrollees in writing or through the Internet at the enrollee's option a list of health care providers participating in the plan. This act requires the list to include, under a separate category or heading, participating advanced practice registered nurses (APRNs).

The act also allows an enrollee of a managed care plan that requires selection of a primary care provider to instead choose a participating, in-network APRN. Under prior law, an enrollee could only select a participating, in-network primary care physician.

Finally, the act requires all MCOs to notify their enrollees as soon as possible when their primary care provider leaves the MCO's provider network. Prior law limited the MCO's notification to an enrollee of a managed care plan that requires the enrollee to select a primary care physician.

**EFFECTIVE DATE: October 1, 2011**

**Public Act 11-204 (House Bill 6472)**  
**An Act Concerning Health Insurance Coverage for Ostomy Supplies**  
**(Signed by the Governor 7/13/2011)**

By law, certain health insurance policies that cover ostomy surgery must also cover medically necessary ostomy appliances and supplies, including collection devices, irrigation equipment and supplies, and skin barriers and protectors. This act increases the maximum annual coverage amount for ostomy appliances and supplies from \$1,000 to \$2,500. The law prohibits insurers from applying any payments for ostomy appliances and supplies toward any durable medical equipment benefit maximum. And such payments cannot be used to decrease policy benefits that exceed the required coverage amount.

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.

Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

**EFFECTIVE DATE: January 1, 2012**

**BACKGROUND**

*Medically Necessary*

The law requires policies to define medically necessary services 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 11-225 (Senate Bill 396)**

#### **An Act Concerning Insurance Coverage for the Screening and Treatment of Prostate Cancer and Prohibiting Differential Payment Rates to Health Care Providers for Colonoscopy or Endoscopic Services Based on Site of Service (Signed by the Governor 7/13/2011)**

Existing law requires certain health insurance plans to cover laboratory and diagnostic tests to detect prostate cancer in men who are (1) symptomatic or in high-risk categories or (2) age 50 or older. This act expands coverage to include prostate cancer treatment if it is “medically necessary” and in accordance with guidelines established by (1) the National Comprehensive Cancer Network, (2) the American Cancer Society, or (3) the American Society of Clinical Oncology.

The act also extends prostate cancer screening requirements to individual and group health insurance policies amended 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. Existing law already applies to such policies delivered, issued, continued, or renewed in the state. (Due to the federal Employee Retirement Income Security Act (ERISA), state health insurance mandates do not apply to self-insured plans.)

Finally, the act requires insurers and other entities that contract with a physician or a physician's group to provide services under a group or individual health insurance policy to establish a payment amount for the physician's services component of the covered colonoscopy or endoscopic services that is the same regardless of where the services are performed. The payment amount must be at least that which would otherwise be paid to the contracted physician or physician's group if the services were performed at a facility

other than an outpatient surgical facility. Entities must establish the payment amount at the request of the contracted physician or physician's group. The act specifies that it does not prohibit a contracted physician or physician's group from agreeing to a different payment method for these services.

This requirement applies to individual and group health insurance companies, HMOs, hospital and medical service corporations, and fraternal benefit societies that deliver, issue, renew, amend, or continue individual and group health insurance policies providing the types of coverage listed above.

**EFFECTIVE DATE: October 1, 2011, except that the provisions on prostate cancer screening and treatment take effect January 1, 2012.**

## BACKGROUND

### *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.

## **Special Act 11-13 (Senate Bill 1153)**

### **An Act Establishing a Task Force to Study Life Insurance Policy and Annuity Conversions and the Provision of Certain Notifications by Life Insurance Companies**

**(Signed by the Governor 7/13/11)**

There is established a task force to examine (1) ways to allow an insured under a life insurance policy or a contract holder of an annuity to convert such policy or annuity to a long-term care policy, and (2) the implications of requiring life insurance companies to notify their policyholders of the option to enter into a life settlement contract as an alternative to the lapse or surrender of a life insurance policy.

Not later than January 1, 2012, the task force shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to insurance, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2012, whichever is later.

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

**Public Act 11-106 (House Bill 6233)**

**An Act Concerning Payment for Repair or Remediation Following a Covered Loss Under a Personal or Commercial Risk Policy**

**(Signed by the Governor 7/8/11)**

The law requires a person who will perform repair or remediation work relating to a claim under a personal or commercial risk insurance policy to give the insured, before any work begins, written notice of the work to be completed and the estimated total price. For losses occurring on or after October 1, 2011, this act voids a work contract between the person performing the work and the insured if the notice is not given. By law, the notice requirement does not apply to repairs (1) made to vehicles covered by an automobile liability insurance policy or (2) performed by registered home improvement contractors.

**EFFECTIVE DATE: October 1, 2011**

**Public Act 11-138 (House Bill 6508)**

**An Act Concerning Timely History Reports for Commercial Risk Insurance Policies**

**(Signed by the Governor 7/8/11)**

By law, when insurers or insureds cancel or do not renew a commercial auto or general liability insurance policy, the insurer must provide their insureds with written reports that include a history of the policy's pricing and premium information, along with a detailed list of incurred losses (i. e. , loss reports). This act extends the reporting requirement to all types of commercial risk insurance, instead of just commercial auto or general liability, and decreases the timeframe for providing certain reports from 60 days to 30 days.

Additionally, under prior law, commercial auto and general liability insurers had to provide principal insureds who requested it a summary of claims information for a period of up to four years before the date of the request. The act (1) expands the requirement to all commercial risk insurers, (2) requires that the request be made in writing, and (3) requires the insurer to report within 30 days after receiving the request. By law, the summary report must include each policy number, each coverage period, the number of claims, the amount of paid losses, and the date of each loss.

**EFFECTIVE DATE: January 1, 2012**

**TIMEFRAME TO FURNISH LOSS REPORT**

Under prior law, when the cancellation or nonrenewal of a policy was due to specified circumstances (e. g. , nonpayment of premium, fraud or material misrepresentation, or willful or reckless acts that increase the hazard insured against), the insurer had to provide the loss report, or an updated report needed to properly rate or obtain coverage from a different insurer, to the insured within 60 days of receiving a written request from

the insured or the insured's authorized producer. The act decreases the timeframe to report from 60 days to 30 days.

By law, an insurer that cancels or does not renew a policy for any other reason than those specified above must provide the insured or authorized producer with the loss report no later than the date notice of nonrenewal or cancellation is furnished.

**Public Act 11-196 (House Bill 6238)**  
**An Act Concerning the Actual Cash Value of a Building**  
**(Signed by the Governor 7/13/11)**

The law provides the standard language for a fire insurance policy (e. g. , homeowners' insurance). It defines the term “actual cash value” as the amount it would cost to repair or replace property with material of like kind and quality.

This act retains the existing definition for insured property, other than a building. It redefines “actual cash value” with respect to an insured building as the amount it would cost to repair or replace the building with material of like kind and quality, minus reasonable depreciation. It defines “depreciation” as a decrease in real property's value over time due to wear and tear.

**EFFECTIVE DATE: January 1, 2012**

**Public Act 11-253 (House Bill 6364)**  
**An Act Concerning the Sunset Date for Personal Risk Insurance Rate Filings and the Procurement of Reinsurance by Domestic Title Insurers**  
**(Signed by the Governor 7/13/11)**

This act extends the sunset date for the “flex rating” law for personal risk insurance (e. g., home, auto, marine, umbrella) from July 1, 2011 to July 1, 2013 (see BACKGROUND).

The act also allows the insurance commissioner to permit a domestic title insurer to purchase reinsurance from an accredited property and casualty reinsurer, but only upon application and when the title insurer executes an affidavit showing that it was unable, after diligent effort, to procure reinsurance from another title insurer that is reasonably consistent with what is fair and appropriate under commonly accepted commercial practices. The title insurer must include the affidavit and a copy of the proposed reinsurance treaty with the application.

The law permits title insurers to purchase reinsurance for all or part of their liability under title insurance policies or reinsurance agreements. They may also reinsure title policies issued by other title insurers on risks located in this or another state. Reinsurance on property located here must be purchased from title insurers licensed here. The insurance commissioner may permit a title insurer to purchase reinsurance from an

insurer not licensed in the state, but only on request and when the unlicensed insurer satisfies the capital and surplus requirements for licensed companies.

**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 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 submit more than one rate filing using the 6% band to the Insurance Department in any 12-month period if 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 for 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 seeking to increase or decrease rates by more than 6% must follow existing rate filing requirements (i. e. , insurers must receive department approval before using the new rates).

The law deems that any filings made under its provisions comply with the rating laws. But the commissioner can determine if they are inadequate or unfairly discriminatory and must 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, 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**  
**Consumer Affairs**

**Public Act 11-195 (House Bill 6234)**

**An Act Concerning Elections of the Executive Boards of Directors of Condominium Unit Owners' Associations and Changes to the Common Interest Ownership Act (Signed by the Governor 7/13/11)**

This act makes the following changes to the Common Interest Ownership Act (CIOA). It:

1. prohibits an (a) executive board member of a residential common interest community association or master association (representing one or more common interest communities) or (b) individual seeking election to such board, from accepting any item of value based on the understanding that doing so will influence the member's or candidate's vote, official action, or judgment; and also prohibits someone from providing or offering something of value to these people;
2. prohibits a community association manager or person providing association management services from campaigning for any person seeking election to an executive board;
3. requires an association to hold a hearing before bringing an action or instituting a proceeding against a unit owner, other than a declarant;
4. allows a unit owner, other than a declarant, to request such a hearing to enforce a right or obligation against an association or another unit owner; and
5. exempts certain buildings from the insurance requirements for units divided by horizontal or vertical boundaries.

The act also prohibits a contract between a common interest community association and an individual providing association management services from including any clause or agreement that indemnifies or holds the association manager harmless against any liability for loss or damage resulting from the manager's negligence or willful misconduct.

**EFFECTIVE DATE: October 1, 2011**

**HEARING REQUIREMENTS FOR ASSOCIATIONS SUBJECT TO CIOA**

*Requirements*

By law, anyone subject to CIOA may bring a court action to enforce a right or obligation imposed by CIOA or an association's declaration or bylaws. Parties to a dispute arising under CIOA, the declaration, or bylaws may agree to resolve the dispute by binding or nonbinding alternative dispute resolution under certain conditions.

The act requires an association, before bringing an action or instituting a proceeding against a unit owner, other than a declarant (developer), to schedule a hearing during a regular or special executive board meeting. The association must notify the unit owner of the hearing date, time, and location at least 10 business days in advance by certified mail, return receipt requested, and regular mail. The notice must also state the nature of the claim against the unit owner.

The act gives the unit owner the right to give oral and written testimony at the hearing, either in person or through a representative. The executive board must consider this testimony when deciding whether to bring an action or institute a proceeding against the unit owner.

Within 30 days after the hearing, the association must notify the unit owner of the executive board's decision by certified mail, return receipt requested, and regular mail.

The act exempts from this hearing requirement an action brought by an association against a unit owner to (1) prevent immediate and irreparable harm or (2) foreclose a lien for an assessment attributable to a unit or related fines imposed against a unit owner.

#### *Hearings Requested By A Unit Owner*

The act allows a unit owner, other than a declarant, to submit a written request to the association for a hearing before the executive board. The unit owner may do this to enforce a right or obligation imposed by CIOA, the declaration, or bylaws against the association or another unit owner, other than a declarant. The written request must state the claim's nature. The association must schedule the hearing within 30 days after receiving the request. The hearing must be held during a regular or special executive board meeting and within 45 days after receiving the request. The association must notify the unit owner of the hearing date, time, and location at least 10 business days in advance by certified mail, return receipt requested, and regular mail. Within 30 days after the hearing, the association must notify the unit owner of the executive board's decision in the same manner.

The act specifies that the association's failure to comply with these hearing requirements does not affect a unit owner's right to bring an action to enforce a right or obligation imposed by CIOA, the declaration, or bylaws.

#### INSURANCE REQUIREMENTS FOR UNITS DIVIDED BY VERTICAL OR HORIZONTAL BOUNDARIES

The law requires an association to obtain property insurance for buildings in the common interest community that contain units with horizontal (i.e., stacked units) or vertical boundaries (i.e., side-by-side units) that comprise or are located within common walls between units. The insurance on such units must include coverage for improvements unit owners installed unless the (1) declaration limits the association's authority to do so or (2) executive board decides not to insure them after giving notice and an opportunity for unit owners to comment.

The act specifies that these requirements do not apply to a building in a common interest community with up to two units divided by a single horizontal or vertical boundary unless the common interest community voluntarily chooses to comply.

## **Acts of Interest to the Insurance Department**

### **Public Act 11-6 (Senate Bill 1239, Section 75)**

#### **An Act Concerning the Budget for the Biennium Ending June 30, 2013, and other Provisions Related to Revenue**

**(Signed by the Governor 5/4/11)**

#### **INSURANCE PREMIUM TAX CREDIT LIMIT**

For 2011 and 2012, the act generally lowers, from 70% to 30%, the amount by which an insurer can reduce its annual insurance premium tax liability through tax credits. It exempts insurance reinvestment fund tax credits from this cap, thus allowing an insurer to continue to apply these credits to reduce its tax liability by up to 70% in 2011 and 2012. It also allows an insurer to offset additional tax liability in these income years if it adds employees. The act makes the credit limit apply to calendar years, rather than income years.

Under the act, an insurer may offset additional tax liability for 2011 and 2012 by an amount equal to \$6,000 times its average net monthly increase in employees, up to 100% of its total tax liability. The average net employee gain must be calculated by adding the insurer's total increase in employees for the applicable year and dividing by 12. In order for an employee to count, he or she must (1) be required to work at least a 35-hour week and (2) not have been employed in Connecticut by the insurer's "related person" within 12 months before the applicable calendar year (see BACKGROUND). A company may not exceed the 30% credit limit if its average net employee gain is zero or less than zero.

(PA 11-61 later amended these provisions to add an additional credit limit for digital animation tax credits and specify the order in which certain credits must be claimed against the insurance premium tax.)

**EFFECTIVE DATE: Upon passage, and applicable to calendar years beginning January 1, 2011.**

### **Special Act 11-6 (Senate Bill 1068)**

#### **An Act Concerning a SWOT Analysis of the State's Insurance and Financial Services Clusters**

The Department of Economic and Community Development shall, within available appropriations, conduct a strengths, weaknesses, opportunities and threats (SWOT) analysis of the state's insurance and financial services clusters and report the results of such analysis to the joint standing committee of the General Assembly having cognizance of matters relating to commerce on or before February 1, 2012.

**Effective from passage**

**Public Act 11-21 (House Bill 6444)**  
**An Act Clarifying the Definition of “Emergency” and “Major Disaster”**  
**(Signed by the Governor 5/24/11)**

This act conforms the statutory definitions of “major disaster” and “emergency” to Department of Emergency Management and Homeland Security usage, for purposes of the civil preparedness and emergency management statutes. It updates the statutes by substituting “emergency management director” for “director of civil preparedness” to reflect the term currently used to describe this official. It also makes technical and conforming changes.

**EFFECTIVE DATE: October 1, 2011**

MAJOR DISASTER AND EMERGENCY

Prior law's definitions of “major disaster” and “emergency” mirrored the federal Stafford Act definitions and applied only when the President determined that federal assistance was warranted. The act includes in the definition of “major disaster” catastrophes that the governor determines are severe enough to warrant declaring a civil preparedness emergency, not just those that the President determines warrant Stafford Act disaster relief.

The act also includes in the definition of “emergency,” situations in which the governor determines that state or federal assistance is necessary to supplement state or local efforts to save lives and protect property, public health and safety, or to avert or lessen the threat of a disaster or catastrophe. Under prior law, “emergency” meant situations in which the President determined that federal assistance was needed to supplement state and local efforts.

**BACKGROUND**

*Stafford Act*

This act constitutes the statutory authority for most federal disaster response activities especially as they pertain to Federal Emergency Management Assistance programs.

*Civil Preparedness Emergencies*

By law, the governor may declare a civil preparedness emergency in the event, or imminent threat, of serious disaster, enemy attack, sabotage, or hostile action. In such cases, the governor may personally take direct operational control of any or all parts of the civil preparedness forces and functions in the state.

**Public Act 11-31 (House Bill 6484)**  
**An Act Concerning the Availability of Accident Records of the State Police**  
**(Signed by the Governor 6/3/11)**

This act sets a 30-day deadline for the State Police to make accident records available to an accident victim who is the subject of the record. Under prior law, the records were available at an unspecified time after a warrant or summons was issued. The act makes

them available after the warrant or summons is issued or within 30 days after the accident, whichever is earlier. But it allows the Department of Public Safety to extend the 30-day period if granting access to the record would compromise an ongoing criminal investigation. By law, unchanged by the act, the records are available for public inspection after the final disposition of any criminal action arising from the accident. The act applies to any memorandum, sketch, chart, written statement, report, or photograph the State Police obtained, prepared, or created in its investigation of an accident involving personal injury or property damage. By law, the State Police must preserve any such accident records for at least 10 years from the date of the accident.  
**EFFECTIVE DATE: October 1, 2011**

**Public Act 11-33 (House Bill 5174)**  
**An Act Concerning State Employees and Training to Deal with Workplace Violence**  
**(Signed by the Governor 6/3/11)**

By January 1, 2012, this act requires the Department of Administrative Services (DAS) commissioner to develop an employee training program on workplace violence awareness, prevention, and preparedness. It requires full-time state employees hired after January 1, 2012, as a condition of employment, to attend the training within six months of being hired. Full-time employees hired before January 1, 2012 must attend the training, but the act creates no deadline for them to do so. The act eliminates the requirement that the DAS commissioner, in consultation with the mental health and addiction services and public safety commissioners, include workplace violence awareness and preparedness in an annual training program for state employees, thus limiting the subjects covered in this program to workplace stress awareness and prevention.  
**EFFECTIVE DATE: October 1, 2011**

**Public Act 11-61 (House Bill 6652, Section 48)**  
**An Act Implementing the Revenue Items in the Budget and Making Budget**  
**Adjustments, Deficiency Appropriations, Certain Revisions to Bill of the Current**  
**Session and Miscellaneous Changes to the General Statutes**

This act revises many provisions of previously adopted 2011 public acts affecting the state budget, taxes, and other laws.

**INSURANCE PREMIUM TAX CREDIT LIMIT**

For the 2011 and 2012 calendar years, PA 11-6 lowered, from 70% to 30%, the maximum amount by which an insurer can reduce its annual insurance premium tax liability through tax credits. PA 11-6 also exempted insurance reinvestment fund credits from the 30% limit, thus allowing an insurer to continue to apply those credits to reduce its annual tax liability by up to 70% in those years.

This act instead classifies insurance premium tax credits into three types and establishes three levels of maximum tax liability that an insurer can offset in calendar years 2011 and 2012 by claiming one or more of these credit types. The three credit types and the maximum tax reduction from each type are:

- Type 1: digital animation credits, 55%
- Type 2: insurance reinvestment fund credits, 70%
- Type 3: all other credits, 30%

The act also specifies the order in which an insurer must apply the three credit types to offset liability (see Table 1).

Table 1: Application of Insurance Premium Tax Credits

<i>Credit Types Claimed</i>	<i>Order of Applying Credits</i>	<i>Maximum Reduction In Tax Liability</i>
Type 3	None	30%
Types 1 & 3	1. Type 3	Type 3 = 30%
	2. Type 1	Sum of two types = 55%
Types 2 & 3	1. Type 3	Type 3 = 30%
	2. Type 2	Sum of two types = 70%
Types 1, 2, & 3	1. Type 3	Type 3 = 30%
	2. Type 1	Type 1 + Type 3 = 55%
	3. Type 2	Sum of all types = 70%
Types 1 & 2	1. Type 1	Type 1 = 55%
	2. Type 2	Sum of two types = 70%

**EFFECTIVE DATE: Upon passage and applicable to calendar years starting on or after January 1, 2011.**

**Public Act 11-77 (Senate Bill 1207)  
An Act Concerning Offers of Compromise  
(Signed by the Governor 7/8/11)**

This act changes the timing of, and eliminates plaintiff's obligation to provide the defendant with information before filing an offer to compromise in medical malpractice actions. An offer to compromise is a written pretrial offer by the plaintiff to settle a civil lawsuit for a specific amount of money.

Under prior law, at least 60 days before filing an offer, the plaintiff had to: (1) state with specificity the damages on which the lawsuit is based, (2) provide a release for medical

records, and (3) disclose all experts who would be testifying about the prevailing professional standard of care. The plaintiff also had to file a certification with the court indicating he or she had provided defendant with all documentation supporting the damages claim. The defendant had 30 days to accept the offer; he or she could not do so after a verdict or court award had been issued.

Under the act, the plaintiff has no obligation to provide the defendant with the information described above, but it cannot make an offer less than 365 days after it filed the suit. The offer is deemed rejected if not accepted (1) within 60 days (in other civil actions, the law gives the defendant 30 days) and (2) before the jury or the court issues an award. The defendant cannot accept an offer after these deadlines unless the plaintiff re-files it.

By law, if the defendant rejects the offer and the plaintiff receives a damage award that equals or exceeds it, the defendant must pay the plaintiff 8% interest on the award plus court-assigned legal fees. In some circumstances, the accrual of interest runs from the date the complaint was filed. In others it runs from the date the offer of compromise was filed.

**EFFECTIVE DATE: October 1, 2011**

**Public Act 11-86 (Senate Bill 1001)  
An Act Creating the First Five Program  
(Signed by the Governor 7/8/11)**

This act authorizes “substantial financial assistance” under existing economic development programs for business development projects that can create jobs and invest funds within specified timeframes. The Department of Economic and Community Development (DECD) commissioner may provide this assistance to up to five businesses per year in FY 12 and 13, respectively (i.e. , “First Five” Program).

The act allows her to provide the assistance only if the governor consents. It exempts First Five projects from having to obtain legislative approval, which the law requires for financial assistance and certain tax credits above specified amounts.

The act also increases the total amount of business tax credits available under the (1) job creation tax credit program, from \$11 million to \$20 million, and (2) Urban and Industrial Sites Reinvestment program, from \$500 million to \$750 million.

**EFFECTIVE DATE: July 1, 2011**

**SUBSTANTIAL FINANCIAL ASSISTANCE**

*Two-Year Time Period*

The act authorizes the DECD commissioner to provide substantial financial assistance to up to five businesses per year in FY 12 and 13, respectively, and to work with the Connecticut Development Authority (CDA) and Connecticut Innovations, Inc. (CII) to

secure financing for the project. CDA makes and guarantees loans for different business development projects; CII provides venture capital for developing new products and techniques.

#### *Manufacturing Assistance Act (MAA)*

The act does not explicitly specify the programs the commissioner may use to fund First Five projects, but suggests she may use MAA funds, which businesses can use to develop land and purchase machinery and equipment. The law limits the amount of MAA funds a project may receive based on its location. Projects in the 17 targeted investment communities qualify for up to 90% funding while those in the other municipalities generally qualify for up to 50% funding. The act exempts First Five projects from these limits, thus qualifying them for up to 100% funding regardless of their location.

#### *Insurance Premium Tax Credit Waivers*

The act also suggests that parties investing in First Five projects qualify for business tax credits. It does so by allowing the commissioner to waive the annual statutory limit on the total amount of credits insurers may claim against the insurance premium tax. The limit is 70% of a taxpayer's pre credit liability for that year. The commissioner may waive this limit for taxpayers claiming credits for investments made under these programs:

1. Urban and Industrial Sites Reinvestment Act (CGS § 32-9t),
2. Job Creation (CGS § 12-217ii),
3. Small Business Job Creation (CGS § 12-217nn),
4. Vocational Rehabilitation Job Creation (CGS § 12-217oo),
5. Film Production Tax Credit (CGS § 12-217j),
6. Film Production Infrastructure (CGS § 12-217kk),
7. Digital Animation Production (CGS § 12-217ll), and
8. Insurance Reinvestment Fund (CGS § 38a-88a).

#### *Increase Credit Authorizations*

PA 11-6 increased the total combined cap for credits under the Job Creation, Small Business Job Creation, and Vocational Rehabilitation Job Creation programs from \$11 million to \$20 million. This act sets the cap for the Job Creation program at \$20 million on its own, but does not eliminate conflicting references to a combined \$20 million cap for the three programs in other statutes.

#### EXEMPTION FROM LEGISLATIVE APPROVAL

The act exempts First Five projects from laws requiring legislative approval for large-scale economic development projects. It exempts them from the law requiring such approval for projects receiving over \$10 million over a two-year period (\$20 million for biotechnology projects). And it exempts them from the law requiring legislative approval for projects requesting over \$20 million in tax credits under the Urban and Industrial Sites Reinvestment Program, which provides credits for (1) building, expanding, or rehabilitating facilities in state-designated municipalities or (2) cleaning up and redeveloping contaminated property in any municipality.

### ELIGIBILITY CRITERIA

Business development projects qualify for First Five funding if they commit to creating jobs or investing funds within the act's timeframes. Thus, a project qualifies if it:

1. creates at least 200 new jobs within 24 months after the commissioner approved assistance or
2. invests at least \$25 million and creates at least 200 new jobs within five years after the commissioner approved the assistance.

The act allows the commissioner to give business development projects preference for assistance if they are also "redevelopment projects," which the act does not define. The commissioner can do this if she believes a project can create at least 200 jobs sooner than 24 months or, for projects investing at least \$25 million, sooner than five years.

### TERMS AND CONDITIONS FOR FINANCIAL ASSISTANCE

The act authorizes the commissioner to take any steps she deems necessary to ensure that a business development project meets its job creation and investment goals. The steps include imposing terms and conditions on repaying state assistance.

### APPROVAL

The commissioner must certify to the governor that a project meets the act's criteria. She may award the assistance only if the governor consents in writing.

### REPORTS

The commissioner must report to the Commerce and Finance, Revenue and Bonding committees on the projects receiving assistance under the act. The reports must indicate the number of jobs created and how they affect the economy. They are due on January 1, 2012, January 1, 2013, and September 1, 2013.

### **Public Act 11-119 (House Bill 6350)**

#### **An Act Concerning the Attorney General's Authority to Enforce Provisions of the Dodd-Frank Wall Street Reform and Consumer Protection Act**

**(Signed by the Governor 7/8/11)**

This act explicitly authorizes the attorney general to bring a civil action in a court of competent jurisdiction to enforce the provisions of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) that state attorneys general are authorized to enforce. It also allows the attorney general to seek any relief that the Dodd-Frank Act authorizes state attorneys general to seek.

**EFFECTIVE DATE: July 1, 2011**

### ATTORNEY GENERAL RESPONSIBILITIES

Under the act, the state attorney general is responsible for duties included in the Dodd-Frank Act (the 2010 federal financial services law). Specifically, the federal act authorizes a state attorney general to bring civil actions to enforce its consumer protection provisions or implementing regulations. Concerning suits against national

banks or federal savings associations, the Dodd-Frank Act permits the attorney general to sue to enforce regulations prescribed by the Bureau of Consumer Financial Protection under the federal act's consumer protection provisions, but not to enforce that act's provisions themselves. The federal act also limits the states' ability to enforce its consumer protection provisions against merchants, retailers, or sellers of nonfinancial goods or services. The federal act permits a wide range of relief in proceedings under federal consumer financial law, but does not allow punitive damages.

The Dodd-Frank Act requires states, before bringing suit to enforce its consumer protection provisions or attendant regulations, to notify the bureau and the applicable federal regulator. If prior notice is not practicable, the state must notify them immediately after bringing the action. It authorizes the bureau to intervene.

In addition, the Dodd-Frank Act:

1. provides that the National Bank Act's provisions on a government's right to oversee corporate affairs of a national bank do not restrict the state's authority to bring an action against a national bank to enforce an applicable law;
2. extends the state's authority to bring suit concerning violations of rules on unfair or deceptive acts or practices regarding mortgage loans to rules that the bureau promulgates (federal law already allowed these suits to enforce rules that the Federal Trade Commission promulgates);
3. makes the bureau the primary authority to enforce provisions of the Real Estate Settlement Procedures Act related to kickbacks and unearned fees, while retaining the state's authority to enforce these provisions;
4. expands the state's authority to bring actions to enforce the federal Truth in Lending Act, including several provisions concerning residential mortgage loans; and
5. specifies that the attorney general (in addition to certain federal entities) may enforce federal regulations pertaining to quality control standards for automated valuation models used to estimate collateral value for mortgage lending purposes (but state enforcement authority does not extend to federally regulated financial institutions or subsidiaries).

## BACKGROUND

### *Dodd-Frank Act*

The Dodd-Frank Act (P. L. 111-203, 124 Stat. 1376 (2010)) was signed into law on July 21, 2010. Among other things, it creates the Bureau of Consumer Financial Protection as a watchdog agency to oversee financial institutions and enforce compliance with consumer financial laws. It also establishes and strengthens consumer protection laws. The act includes several provisions authorizing enforcement by state attorneys general.

**Public Act 11-128 (House Bill 6438, Section 2)  
An Act Concerning Probate Court Operations  
(Signed by the Governor 7/8/11)**

This act makes several changes to probate law. Among other provisions, it extends worker's compensation coverage to elected probate court judges.

**Public Act 11-140 (House Bill 6525, Section 2)  
An Act Concerning the Continuance of the Majority Leaders' Job Growth  
Roundtable  
(Signed by the Governor 7/8/11)**

This act establishes and modifies several economic development programs, makes structural and procedural changes to two quasi-public state development agencies, and requires two studies. Only Section 2 of the law, related to insurance reinvestment tax credits, is summarized in this report.

Section 2 of the act allows business taxpayers to transfer insurance reinvestment tax credits to their affiliates.

**INSURANCE REINVESTMENT FUND PROGRAM**

This program authorizes insurance premium, corporation business, and personal income tax credits for taxpayers investing in insurance businesses through a state-certified insurance reinvestment fund. Under prior law, taxpayers could only apply credits against their tax liability or sell them (i.e., assign them) to another taxpayer. The act also allows them to transfer the credit to an affiliated business or entity.

**EFFECTIVE DATE: Upon passage**

**Public Act 11-150 (House Bill 6600)  
An Act Implementing the Recommendations of the Legislative Paperless Task Force  
and the Task Force to Study the Reduction of State Agency Paper and Duplicative  
Procedures  
(Signed by the Governor 7/8/11)**

This act makes several changes in the laws to reduce state agencies' paper usage. It allows (1) fewer printed copies of several legislative documents and publications to be produced and (2) bills and amendments to be posted to the legislature's website rather than placed on legislators' desks before they are voted on. It generally provides for more limited distribution of several printed documents and publications and, in some cases, requires an individual to make a specific request to receive a printed copy.

The act also requires agencies to electronically submit their proposed regulations to the Regulations Review Committee. It allows agencies to respond to Freedom of Information

Act (FOIA) requests electronically or by facsimile in certain circumstances and reduces the number of copies of required reports they must file with the State Library.

Lastly, the act requires numerous one-time reports by agencies. The reports generally must include recommendations for reducing costs and paper usage.

**EFFECTIVE DATE: July 1, 2011, except the sections requiring (1) reports by agencies, conversion of applications and forms to electronic format, and standards and guidelines for electronic records, which are effective upon passage, and (2) electronic submissions of proposed regulations, which are effective October 1, 2011.**

#### *Other Distribution Requirements*

The act requires a specific request before printed copies of the House and Senate journals are provided to legislators, state officers, and county bar libraries (§ 6). Similarly, it requires a specific request before printed copies of statutes and public and special acts are provided to legislators, probate courts, police departments, assistant attorneys general, and county law libraries (§ 10). It also specifies that veterans' organizations in state-furnished office space in Hartford must make a specific request to receive annotated copies of the revised statutes and supplements (§ 14).

The act specifies that House and Senate journals and calendars will be reproduced only on regular session days. It also requires (1) the Legislative Commissioners' Office (LCO) to distribute only a limited number of engrossed bills and resolutions and (2) LCO, not the printer, to assign a bill's file number (§§ 2 & 3).

The act requires each bill reported favorably to be posted on the legislature's website. It eliminates the requirement that the secretary of the state send a printed copy of all bills reported favorably to the Library of Congress; UConn, Wesleyan University, and Quinnipiac University libraries; and Yale University's law library. She must still send a printed copy to the State Library and UConn law library. The act also reduces, from seven to two, the number of copies of each printed bill that the House and Senate clerks must reserve for her use (§ 5).

The act eliminates a requirement that the secretary of the state distribute to town and Superior Court clerks printed copies of each public act that takes effect upon passage (§§ 15 & 29). It allows the House and Senate clerks to send municipalities electronic rather than printed legislative bulletins and record indexes (§ 2). It also requires the State Library to send, upon request, electronic, rather than printed, copies of (1) bills to high schools and colleges and (2) various legislative documents to law libraries (§§ 11 & 13).

#### AGENCY REQUIREMENTS

The act requires agencies to send their proposed regulations to the Regulation Review Committee electronically, rather than sending 18 paper copies as prior law required. It also requires electronic, rather than paper, submission of the proposed regulations and accompanying fiscal notes to the (1) Office of Fiscal Analysis and (2) committees of cognizance of the proposed regulation's subject matter (§§ 18 & 19).

The act requires each executive branch agency to (1) use email to notify and correspond with clients whenever possible and permitted by law and to request statutory changes where it is not permitted, (2) explore the feasibility of converting all applications and forms used by the public to electronic format, and (3) create an inventory of all forms the agency uses (§§ 23 & 25).

The act permits an agency to provide records electronically or by fax in response to an FOIA request, unless the requestor (1) does not have access to a computer or fax machine or (2) requests a certified copy (§§ 21 & 22).

By law, if (1) a task force, commission, or committee is appointed by the governor, the General Assembly, or both and required to report its findings or (2) a state agency is required to submit a report to the General Assembly or a legislative committee, that report must be submitted to the Senate and House clerks, state librarian, and Office of Legislative Research (OLR). The act requires electronic submission of reports to the House and Senate clerks and OLR. It eliminates the requirement that the submitting entity file as many copies with the state librarian as it and the librarian jointly agree are appropriate and instead requires that only one copy be filed with the library (§ 12).

The act also requires the state librarian, by January 1, 2012, to develop standards and guidelines for preserving and authenticating electronic records. In doing so, he or she must consult with the Department of Administrative Services (DAS) commissioner, the chief information officer (CIO) of the Department of Information and Technology (DOIT), the Legislative Management Committee's executive director, and the chief court administrator (§ 28).

**Public Act 11-205 (House Bill 6474)**  
**An Act Concerning the Resolution of Liens in Workers' Compensation Cases**  
**(Signed by the Governor 7/13/11)**

This act reduces an employer's claim for reimbursement of workers' compensation benefits paid to an employee when the employee sues someone who is liable for the injury and the employer does not join the suit. But the reduction does not apply if reimbursement is to the (1) state or a political subdivision, including a local public agency, as the employer or (2) Second Injury Fund administrator.

By law, the employee or employer or Second Injury Fund administrator paying benefits can bring such a lawsuit. The individual bringing the suit must immediately notify the others in writing and the others can join the suit. Under prior law, if the others did not join the suit within 30 days, their right of action against the party in question abates. The act provides that the right of action does not abate if the employer, insurer, or administrator fails to join the lawsuit but gives written notice of a lien. By law, an employer, its insurance carrier, or the Second Injury Fund paying benefits to an injured employee has a lien on any judgment or settlement the employee receives if they provide notice of the lien before judgment or settlement.

**EFFECTIVE DATE: July 1, 2011**

### EMPLOYER'S REDUCED CLAIM

By law, an injured employee eligible for workers' compensation benefits can sue someone who is liable for damages for the injury, except for an employer who complies with the workers' compensation law or another employee. An employer who has paid or is obligated to pay workers' compensation benefits to the employee can also sue or join an employee's lawsuit in order to be reimbursed for benefits paid.

By law, if the employer and employee are both plaintiffs and recover damages, these are apportioned so that the employer's claim takes precedence, after deductions for reasonable and necessary expenses, including attorneys' fees incurred by the employee. Under the act, if the employee brings the action, the employer's claim is reduced by one-third of the amount to be reimbursed to the employer unless the parties agree otherwise. The reduction amount is solely for the employee's benefit. But the reduction does not apply if reimbursement is to the (1) state or a political subdivision, including a local public agency, as the employer or (2) Second Injury Fund administrator.

### BACKGROUND

#### *Second Injury Fund*

This fund provides workers' compensation insurance coverage to workers whose employers failed to provide it. By law, the fund's administrator can also sue or join an employee's lawsuit.

### **Public Act 11-211 (House Bill 6557)**

#### **An Act Concerning Liability for the Recreational Use of Lands (Signed by the Governor 7/13/11)**

This act limits the liability of municipalities, other political subdivisions of the state, municipal corporations, special districts, and water or sewer districts that make certain types of land available to the public without charge for recreational purposes. Under the act, these entities, unlike other landowners, remain liable regarding certain structures, fields, or roads on such entities' land. Specifically, the act's liability limitation does not apply to:

1. swimming pools, playing fields or courts, playgrounds, buildings with electrical service, or machinery attached to the land, if these are in the municipality's or other entity's possession and control; and
2. paved, public, through roads that are open to the public for the operation of four-wheeled private passenger cars.

Existing law, unchanged by the act, limits the liability of political subdivisions of the state in other circumstances (see BACKGROUND).

For all landowners (not just municipalities and the other entities listed above), the act adds bicycling to the non-exclusive list of recreational purposes for which the landowner may make the land available to the public and enjoy limited liability.

**EFFECTIVE DATE: October 1, 2011**