



# House of Representatives

General Assembly

**File No. 185**

January Session, 2005

House Bill No. 6863

*House of Representatives, April 5, 2005*

The Committee on Insurance and Real Estate reported through REP. O'CONNOR of the 35th Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

## **AN ACT MAKING MINOR AND TECHNICAL CHANGES TO THE INSURANCE STATUTES.**

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

1 Section 1. Subsection (d) of section 38a-478n of the general statutes is  
2 repealed and the following is substituted in lieu thereof (*Effective*  
3 *October 1, 2005*):

4 (d) (1) Not later than five business days after receiving a written  
5 request from the commissioner, enrollee or any provider acting on  
6 behalf of an enrollee with the enrollee's consent, a managed care  
7 organization whose enrollee is the subject of an appeal shall provide to  
8 the commissioner, enrollee or any provider acting on behalf of an  
9 enrollee with the enrollee's consent, written verification of whether the  
10 enrollee's managed care plan is fully insured, self-funded, or otherwise  
11 funded. If the plan is a fully insured plan or a self-insured  
12 governmental plan, the managed care organization shall send: (A)  
13 Written certification to the commissioner or reviewing entity, as

14 determined by the commissioner, that the benefit or service subject to  
15 the appeal is a covered benefit or service; (B) a copy of the entire policy  
16 or contract between the enrollee and the managed care organization,  
17 except that with respect to a self-insured governmental plan, (i) the  
18 managed care organization shall notify the plan sponsor, and (ii) the  
19 plan sponsor shall send, or require the managed care organization to  
20 send, such copy; or (C) written certification that the policy or contract  
21 is accessible to the review entity electronically and clear and simple  
22 instructions on how to electronically access the policy or contract.

23 (2) Failure of the managed care organization to provide information  
24 or notify the plan sponsor in accordance with subdivision (1) of this  
25 subsection within said five-business-day period or before the  
26 expiration of the thirty-day period for appeals set forth in subdivision  
27 (1) of subsection (b) of this section, whichever is later as determined by  
28 the commissioner, shall (A) create a presumption on the review entity,  
29 solely for purposes of accepting an appeal and conducting the review  
30 pursuant to subdivision (4) of subsection (b) of this section, that the  
31 benefit or service is a covered benefit under the applicable policy or  
32 contract, except that such presumption shall not be construed as  
33 creating or authorizing benefits or services in excess of those that are  
34 provided for in the enrollee's policy or contract, and (B) entitle the  
35 commissioner to require the managed care organization from whom  
36 the enrollee is appealing a medical necessity determination to  
37 reimburse the department for the expenses related to the appeal,  
38 including, but not limited to, expenses incurred by the review entity.

39 Sec. 2. Subsection (a) of section 38a-769 of the general statutes is  
40 repealed and the following is substituted in lieu thereof (*Effective*  
41 *October 1, 2005*):

42 (a) Any person, partnership, association or corporation [, resident,  
43 or with] that is resident in this state or has its principal place of  
44 business in this state, or a nonresident of this state who is not licensed  
45 in any other state, desiring to act within this state as a public adjuster,  
46 casualty adjuster, motor vehicle physical damage appraiser, certified

47 insurance consultant, surplus lines broker or desiring to engage in any  
48 insurance-related occupation for which a license is deemed necessary  
49 by the commissioner, other than an occupation as an insurance  
50 producer, shall make a written application to the commissioner for a  
51 resident license. Any other person, partnership, association or  
52 corporation desiring to so act or to engage in any insurance-related  
53 occupation for which a license is deemed necessary by the  
54 commissioner, other than an occupation as an insurance producer,  
55 shall make a written application to the commissioner for a nonresident  
56 license. No application for a nonresident license shall be granted  
57 unless the applicant holds an equivalent license from any other state.  
58 Any application for a resident or nonresident license shall be made for  
59 each name or designation under which such business shall be  
60 conducted, in such form as the commissioner prescribes, stating the  
61 line or lines of insurance for which the applicant desires such license  
62 and any other business which the applicant desires also to transact. All  
63 initial applications shall be accompanied by a nonrefundable filing fee  
64 specified in section 38a-11. The commissioner shall cause to be made  
65 such inquiry and examination as to the qualifications of each such  
66 applicant as the commissioner deems necessary.

67 Sec. 3. Subsection (c) of section 38a-53 of the general statutes is  
68 repealed and the following is substituted in lieu thereof (*Effective*  
69 *October 1, 2005*):

70 (c) In addition to such annual report and the quarterly report  
71 required under subsection (b) of this section, the commissioner,  
72 whenever [he] the commissioner determines that more frequent  
73 reports are required because of certain factors or trends affecting  
74 companies writing a particular class or classes of business or because  
75 of changes in the company's management or financial or operating  
76 condition, may require any insurance company or health care center  
77 doing business in this state to file financial statements on other than an  
78 annual or quarterly basis.

79 Sec. 4. Subdivision (2) of subsection (b) of section 38a-55 of the

80 general statutes is repealed and the following is substituted in lieu  
81 thereof (*Effective October 1, 2005*):

82 (2) Nothing in this subsection shall be construed as prohibiting a  
83 domestic insurer, health care center or fraternal benefit society from  
84 pledging, hypothecating or encumbering any assets in connection  
85 with: (A) Transactions in the ordinary course of business, including,  
86 but not limited to: (i) Complying with any statutory requirement, (ii)  
87 reinsurance transactions otherwise in compliance with applicable  
88 statutory requirements, or (iii) investments or investment practices  
89 otherwise in compliance with applicable statutory requirements,  
90 including, but not limited to, securities lending, repurchase  
91 transactions, reverse repurchase transactions, swap, futures and  
92 options transactions, and any other transactions which are not  
93 prohibited by the investment law and regulations of this state; (B)  
94 transactions subject to the provisions of sections 38a-129 to 38a-140,  
95 inclusive; or (C) any other transaction deemed excluded by the  
96 Insurance Commissioner. Assets pledged, hypothecated or  
97 encumbered pursuant to subparagraph (A), (B) or (C) of this  
98 [subsection,] subdivision shall not be charged against the limits set  
99 forth in subdivision (1) of this subsection.

100 Sec. 5. Subsection (c) of section 38a-60 of the general statutes is  
101 repealed and the following is substituted in lieu thereof (*Effective*  
102 *October 1, 2005*):

103 (c) If such emergency plan is adopted, it may provide that it will  
104 become operative automatically during any such national emergency  
105 and, notwithstanding any contrary provision of the law or the charter  
106 or bylaws of the company, may contain any provisions reasonably  
107 necessary for the operation of the company during any such national  
108 emergency. Such provisions need not be consistent with the  
109 comparable provisions stated in subsection (b) [above] of this section.  
110 Such provisions may provide, among other things, for (1) the  
111 designation of persons who may call a meeting of the board of  
112 directors; (2) the quorum and notice requirements for, and location of,

113 any such meeting; (3) the filling of vacancies on the board of directors;  
114 (4) a succession list of persons by name or title who will succeed to  
115 positions of higher rank; (5) the establishment of the principal office of  
116 the company at a new location in or out of the state.

117 Sec. 6. Subsection (b) of section 38a-92d of the general statutes is  
118 repealed and the following is substituted in lieu thereof (*Effective*  
119 *October 1, 2005*):

120 (b) Except as otherwise permitted by the commissioner, no  
121 deduction shall be made for anticipated salvage in computing case  
122 basis loss reserves, unless that salvage is held by or under the control  
123 of the financial guaranty insurance corporation and would qualify as  
124 an admitted asset under this title or unless that salvage constitutes or is  
125 secured by a letter of credit which is approved by the commissioner or  
126 complies with the criteria set forth in [subsection] subdivision (4) of  
127 section 38a-92a.

128 Sec. 7. Subsection (b) of section 38a-298 of the general statutes is  
129 repealed and the following is substituted in lieu thereof (*Effective*  
130 *October 1, 2005*):

131 (b) For purposes of subdivisions (2), (3) and (4) of subsection (a) of  
132 this section, the following procedures shall be used:

133 (1) A contraction, hyphenated word or numerals and letters, when  
134 separated by spaces, shall be counted as one word;

135 (2) A unit of words ending with a period, semicolon or colon,  
136 excluding headings and captions, shall be counted as a sentence;

137 (3) A syllable is a unit of spoken language consisting of one or more  
138 letters of a word as divided by an accepted dictionary;

139 (4) Where the dictionary shows two or more equally acceptable  
140 pronunciations of a word, the pronunciation containing fewer syllables  
141 shall be used;

142 (5) Numerals when separated by spaces may be counted as one  
143 syllable.

144 Sec. 8. Subsection (b) of section 38a-615 of the general statutes is  
145 repealed and the following is substituted in lieu thereof (*Effective*  
146 *October 1, 2005*):

147 (b) In addition to such annual report and the quarterly report  
148 required under subsection (a) of this section, the commissioner,  
149 whenever [he] the commissioner determines that more frequent  
150 reports are required because of certain factors or trends affecting  
151 companies writing a particular class or classes of business or because  
152 of changes in the company's management or financial or operating  
153 condition, may require any fraternal benefit society licensed under  
154 sections 38a-595 to 38a-626, inclusive, 38a-631 to 38a-640, inclusive, and  
155 38a-800 to file financial statements on other than an annual or  
156 quarterly basis.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2005</i>	38a-478n(d)
Sec. 2	<i>October 1, 2005</i>	38a-769(a)
Sec. 3	<i>October 1, 2005</i>	38a-53(c)
Sec. 4	<i>October 1, 2005</i>	38a-55(b)(2)
Sec. 5	<i>October 1, 2005</i>	38a-60(c)
Sec. 6	<i>October 1, 2005</i>	38a-92d(b)
Sec. 7	<i>October 1, 2005</i>	38a-298(b)
Sec. 8	<i>October 1, 2005</i>	38a-615(b)

**INS**      *Joint Favorable*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

---

**OFA Fiscal Note**

**State Impact:**

Agency Affected	Fund-Effect	FY 06 \$	FY 07 \$
Insurance Dept.	IF - None	None	None

Note: IF=Insurance Fund

**Municipal Impact:** None

**Explanation**

The bill expands the type of information a managed care organization (MCO) must provide for certain information requests. This has no fiscal impact.

The bill also makes other various changes, none of which have a fiscal impact.

**OLR Bill Analysis**

HB 6863

**AN ACT MAKING MINOR AND TECHNICAL CHANGES TO THE INSURANCE STATUTES****SUMMARY:**

The bill expands the type of information a managed care organization (MCO) must provide when responding to the insurance commissioner's, an enrollee's, or a provider's request for information related to an enrollee's appeal under a self-insured governmental health care contract. By law, an MCO must provide instructions on how to access an electronically available fully insured policy under which an appeal is brought. This bill requires an MCO to similarly send instructions on how to access an electronically available self-insured governmental contract under which an appeal is brought. Information must be provided within five days of the request.

The bill also makes technical and conforming changes in the insurance statutes.

EFFECTIVE DATE: October 1, 2005

**BACKGROUND*****Related Bill***

SB 1002 extends appeal requirements to health insurers and eliminates the requirement that an MCO send information related to a self-insured governmental health plan, including a copy of the plan contract, to the insurance commissioner, an enrollee, or a provider.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Report

Yea 15    Nay 0