



Substitute Senate Bill No. 554

Public Act No. 06-54

AN ACT MAKING REVISIONS TO THE INSURANCE STATUTES.

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

Section 1. Subsection (a) of section 38a-19 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

(a) Any person or insurer aggrieved by any order or decision of the commissioner made without a hearing may, not later than thirty days after notice of the order to the person or insurer, make written request to the commissioner for a hearing on the order or decision. The commissioner shall hear such party or parties not later than [twenty] thirty days after receipt of such request and shall give not less than ten days' written notice of the time and place of the hearing. Not later than [fifteen] forty-five days after such hearing, the commissioner shall affirm, reverse or modify his previous order or decision, specifying his reasons therefor. Pending such hearing and decision on such hearing the commissioner may suspend or postpone the effective date of his previous order or decision.

Sec. 2. Section 38a-102d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

Substitute Senate Bill No. 554

(a) In addition to investments in common stock, preferred stock, debt obligations and other securities permitted under sections 38a-102 to 38a-102h, inclusive, a domestic insurer may also: (1) Invest in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries or affiliates, amounts which do not exceed the lesser of ten per cent of such insurer's assets or fifty per cent of such insurer's surplus as regards policyholders, provided after such investments, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of such investments, investments in domestic or foreign insurance subsidiaries or affiliates shall be excluded, and there shall be included: (A) Total net moneys or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary or affiliate, including all organizational expenses and contributions to capital and surplus of such subsidiary or affiliate whether or not represented by the purchase of capital stock or issuance of other securities, and (B) all amounts expended in acquiring additional common stock, preferred stock, debt obligations and other securities and all contributions to the capital and surplus, of a subsidiary or affiliate subsequent to its acquisition or formation; (2) invest any amount in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries or affiliates engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer, provided each such subsidiary or affiliate agrees to limit its investments in any asset so that such investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in subdivision (1) of this subsection or in sections 38a-102 to 38a-102h, inclusive, applicable to the insurer. For purposes of this subdivision, "the total investment of the insurer" includes: (A) Any direct investment by the insurer in an asset, and (B) the insurer's proportionate share of any investment in an asset by any subsidiary or affiliate of the insurer, which shall be calculated by

Substitute Senate Bill No. 554

multiplying the amount of the subsidiary's or affiliate's investment by the percentage of the ownership of such subsidiary or affiliate; and (3) with the approval of the commissioner, invest any greater amount in common stock, preferred stock, debt obligations or other securities of one or more subsidiaries or affiliates, provided after such investment the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(b) In determining the financial condition of an insurance company, its investments in subsidiaries or affiliates shall be valued in accordance with any applicable valuation method approved by the commissioner and consistent with procedures promulgated by the National Association of Insurance Commissioners.

(c) With respect to the activities conducted by a domestic insurer's subsidiaries, the commissioner shall have the power to: (1) Order said company to curtail the conduct of any activity if he finds, after notice and opportunity to be heard, that such activity is not lawful or is against public policy or that the continuation of such activity is materially adverse to the interests of the insurer's policyholders; and (2) require separate books, accounts and records for such classes of activities of the insurance company subsidiary as he shall determine, which books, accounts and records shall be so maintained as to disclose clearly and accurately the nature and details of such activities. The commissioner may determine that an activity is materially adverse to policyholders if he finds that subsidiaries are being used to avoid the quantitative limitations directly applicable to insurers under section 38a-102c.

Sec. 3. Subdivision (2) of subsection (a) of section 38a-226c of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

Substitute Senate Bill No. 554

(2) Each utilization review company shall maintain and make available a written description of the appeal procedure by which either the enrollee or the provider of record may seek review of determinations not to certify an admission, service, procedure or extension of stay. The procedures for appeals shall include the following:

(A) Each utilization review company shall notify in writing the enrollee and provider of record of its determination on the appeal as soon as practical, but in no case later than thirty days after receiving the required documentation on the appeal.

(B) On appeal, all determinations not to certify an admission, service, procedure or extension of stay shall be made by a licensed practitioner of the [medical] healing arts.

Sec. 4. Subsection (d) of section 38a-478n of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) (1) Not later than five business days after receiving a written request from the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, a managed care organization or health insurer whose enrollee is the subject of an appeal shall provide to the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, written verification of whether the enrollee's plan is fully insured, self-funded, or otherwise funded. If the plan is a fully insured plan or a self-insured governmental plan, the managed care organization or health insurer shall send: (A) Written certification to the commissioner or reviewing entity, as determined by the commissioner, that the benefit or service subject to the appeal is a covered benefit or service; (B) a copy of the entire policy or contract between the enrollee and the managed care organization or health insurer, except that with respect to a self-

Substitute Senate Bill No. 554

insured governmental plan, (i) the managed care organization or health insurer shall notify the plan sponsor, and (ii) the plan sponsor shall send, or require the managed care organization or health insurer to send, such copy; or (C) written certification that the policy or contract is accessible to the review entity electronically and clear and simple instructions on how to electronically access the policy or contract.

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

Sec. 5. Subsection (a) of section 38a-478s of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Nothing in sections 38a-478 to 38a-478o, inclusive, as amended, shall be construed to apply to the arrangements of managed care organizations or health insurers offered to individuals covered under self-insured [health plans] employee welfare benefit plans established

Substitute Senate Bill No. 554

pursuant to the federal Employee Retirement Income Security Act of 1974.

Approved May 8, 2006