



# Senate

General Assembly

**File No. 205**

February Session, 2006

Substitute Senate Bill No. 554

*Senate, March 29, 2006*

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

## **AN ACT MAKING REVISIONS TO THE INSURANCE STATUTES.**

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

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2 repealed and the following is substituted in lieu thereof (*Effective*  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

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

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 Section 38a-102d of the general statutes is repealed and the  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

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

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

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

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

78 Sec. 3. Subdivision (2) of subsection (a) of section 38a-226c of the  
79 2006 supplement to the general statutes is repealed and the following  
80 is substituted in lieu thereof (*Effective October 1, 2006*):

81 (2) Each utilization review company shall maintain and make  
82 available a written description of the appeal procedure by which either  
83 the enrollee or the provider of record may seek review of

84 determinations not to certify an admission, service, procedure or  
85 extension of stay. The procedures for appeals shall include the  
86 following:

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

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

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

97 (d) (1) Not later than five business days after receiving a written  
98 request from the commissioner, enrollee or any provider acting on  
99 behalf of an enrollee with the enrollee's consent, a managed care  
100 organization or health insurer whose enrollee is the subject of an  
101 appeal shall provide to the commissioner, enrollee or any provider  
102 acting on behalf of an enrollee with the enrollee's consent, written  
103 verification of whether the enrollee's plan is fully insured, self-funded,  
104 or otherwise funded. If the plan is a fully insured plan or a self-insured  
105 governmental plan, the managed care organization or health insurer  
106 shall send: (A) Written certification to the commissioner or reviewing  
107 entity, as determined by the commissioner, that the benefit or service  
108 subject to the appeal is a covered benefit or service; (B) a copy of the  
109 entire policy or contract between the enrollee and the managed care  
110 organization or health insurer, except that with respect to a self-  
111 insured governmental plan, (i) the managed care organization shall  
112 notify the plan sponsor, and (ii) the plan sponsor shall send, or require  
113 the managed care organization to send, such copy; or (C) written  
114 certification that the policy or contract is accessible to the review entity  
115 electronically and clear and simple instructions on how to  
116 electronically access the policy or contract.

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

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

137 (a) Nothing in sections 38a-478 to 38a-478o, inclusive, as amended,  
 138 shall be construed to apply to the arrangements of managed care  
 139 organizations offered to individuals covered under self-insured [health  
 140 plans] employee welfare benefit plans established pursuant to the  
 141 federal Employee Retirement Income Security Act of 1974.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2006</i>	38a-19(a)
Sec. 2	<i>October 1, 2006</i>	38a-102d
Sec. 3	<i>October 1, 2006</i>	38a-226c(a)(2)
Sec. 4	<i>from passage</i>	38a-478n(d)
Sec. 5	<i>from passage</i>	38a-478s(a)

**INS**      *Joint Favorable Subst.*

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:

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***OFA Fiscal Note***

***State Impact:*** None

***Municipal Impact:*** None

***Explanation***

The bill makes various revisions to the insurance statutes, none of which have a fiscal impact.

***The Out Years***

***State Impact:*** None

***Municipal Impact:*** None

**OLR Bill Analysis**  
**sSB 554**

***AN ACT MAKING REVISIONS TO THE INSURANCE STATUTES.***

**SUMMARY:**

This bill makes a number of substantive and technical revisions to the insurance statutes. It (1) increases the time the insurance commissioner has to hear and decide contested cases related to denied licenses, rates, or forms; (2) allows an insurer to invest in its affiliates, subject to the same limitations and requirements that apply to investments in subsidiaries; (3) requires self-insured governmental health plans to provide information regarding a plan under which an appeal is made within five business days of receiving a request; and (4) requires a licensed practitioner of the healing arts, instead of the medical arts, to certify a utilization review company's decision following an appeal to not authorize an admission, service, procedure, or extended hospital stay.

**EFFECTIVE DATE:** October 1, 2006, except for the self-insured governmental health plan provision and a technical change, which are effective upon passage.

**CONTESTED CASE HEARING TIMEFRAMES**

Current law requires the commissioner to (1) hold a hearing within 20 days of receiving a request from a person or insurer aggrieved by an order or decision of hers and (2) render a decision within 15 days of the hearing. The bill increases the timeframes to 30 days in which to hold a hearing and 45 days to issue her decision.

**INVESTMENTS IN AFFILIATES**

By law, and unchanged by the bill, an insurer may invest in one or more of its subsidiaries, subject to certain limitations and

requirements. The bill allows an insurer to invest in its affiliates, subject to the same limitations and requirements that apply to investments in subsidiaries.

The bill allows an insurer to invest in the common stock, preferred stock, debt obligations, or other securities of one or more of its affiliates in an amount up to the lesser of 10% of the insurer's assets or 50% of its surplus if, after the investment, the insurer's surplus is reasonable in relation to its outstanding liabilities and adequate for its financial needs.

Investments in domestic and out-of-state insurance company affiliates are not included in calculating the amount of the investments, but the following items must be:

1. the total amount spent and obligations assumed in the acquisition or formation of an affiliate, including organization expenses and contributions to capital and surplus and
2. all amounts spent in acquiring additional common or preferred stock, debt obligations, and other securities and contributions to the capital and surplus of an affiliate after its acquisition or formation.

Insurers may invest any amount in the common or preferred stock, debt obligations, and other securities of one or more affiliates engaged or exclusively organized to engage in the ownership and management of the insurer's investment, if the affiliate agrees to limit its investments so that they will not cause the insurer's total investments to exceed the investment limitations specified. "Total investment of the insurer" includes (1) any direct investments made by the insurer in assets and (2) the insurer's proportionate share of an investment by an affiliate, which must be calculated by multiplying the amount of the affiliate's investment by the parent insurer's percentage ownership of it.

With the insurance commissioner's approval, an insurer may invest

a greater amount in the common or preferred stock, debt obligations, or other securities of one or more affiliates if, after such investment, the insurer's surplus is reasonable in relation to its outstanding liabilities and adequate for its financial needs.

In determining an insurer's financial condition, its investments in affiliates must be valued using a method (1) approved by the commissioner and (2) consistent with procedures established by the National Association of Insurance Commissioners.

### **REQUEST FOR INFORMATION FOR APPEAL**

By law, and unchanged by the bill, an insurer or managed care organization (MCO) must provide the insurance commissioner, an enrollee, or a provider with certain appeal-related information within five business days of receiving a request. Failure to do so subjects the insurer or MCO to a fine of \$100 for each day of violation. The information includes written verification that the plan is fully insured, self-insured, or otherwise funded.

If the plan is fully insured, current law requires the insurer or MCO to also send: (1) written certification to the commissioner or designated review entity that the benefit or service appealed is covered; (2) written certification that the policy or contract is accessible electronically, along with clear and simple instructions on how to access it; or (3) a copy of the entire policy or contract between the enrollee and the MCO. Under the bill, the insurer or MCO must also send this information if the plan is a self-insured governmental health plan, but with respect to forwarding a copy of the contract, an MCO must notify the plan sponsor, who must send or direct the MCO to send the copy. (The bill does not similarly require an insurer to notify the plan sponsor.)

Under the bill, the MCO's failure to notify the plan sponsor within the five-business-day period or before the 30-day appeal period ends, whichever is later as determined by the commissioner, (1) creates a presumption that the benefit or service is a covered benefit for

purposes of accepting the appeal for full review and (2) entitles the commissioner to require the MCO to reimburse the Insurance Department for appeal-related expenses. The presumption established does not create or authorize benefits or services exceeding those in the enrollee's policy or contract. By law, and unchanged by the bill, an insurer's or MCO's failure to provide information within the specified timeframes also creates the presumption and permits the commissioner to require the insurer or MCO to reimburse the department for appeal-related expenses.

**UTILIZATION REVIEW APPEAL DECISION**

Current law requires a utilization review company to have a licensed practitioner of the medical arts to certify appeal determinations to not certify an admission, service, procedure, or extended hospital stay. The bill instead requires a licensed practitioner of the healing arts certify the determination. Connecticut statutes define the practice of "healing arts" as the practice of medicine, chiropractic, podiatry, natureopathy, and optometry.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 18    Nay 0    (03/16/2006)