



General Assembly

February Session, 2006

Raised Bill No. 554

LCO No. 2650

02650_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

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 Section 38a-102d of the general statutes is repealed and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

3 (a) In addition to investments in common stock, preferred stock,
4 debt obligations and other securities permitted under sections 38a-102
5 to 38a-102h, inclusive, a domestic insurer may also: (1) Invest in
6 common stock, preferred stock, debt obligations and other securities of
7 one or more subsidiaries or affiliates, amounts which do not exceed the
8 lesser of ten per cent of such insurer's assets or fifty per cent of such
9 insurer's surplus as regards policyholders, provided after such
10 investments, the insurer's surplus as regards policyholders will be
11 reasonable in relation to the insurer's outstanding liabilities and
12 adequate to its financial needs. In calculating the amount of such
13 investments, investments in domestic or foreign insurance subsidiaries
14 or affiliates shall be excluded, and there shall be included: (A) Total net
15 moneys or other consideration expended and obligations assumed in
16 the acquisition or formation of a subsidiary or affiliate, including all
17 organizational expenses and contributions to capital and surplus of

18 such subsidiary or affiliate whether or not represented by the purchase
19 of capital stock or issuance of other securities, and (B) all amounts
20 expended in acquiring additional common stock, preferred stock, debt
21 obligations and other securities and all contributions to the capital and
22 surplus, of a subsidiary or affiliate subsequent to its acquisition or
23 formation; (2) invest any amount in common stock, preferred stock,
24 debt obligations and other securities of one or more subsidiaries or
25 affiliates engaged or organized to engage exclusively in the ownership
26 and management of assets authorized as investments for the insurer,
27 provided each such subsidiary or affiliate agrees to limit its
28 investments in any asset so that such investments will not cause the
29 amount of the total investment of the insurer to exceed any of the
30 investment limitations specified in subdivision (1) of this subsection or
31 in sections 38a-102 to 38a-102h, inclusive, applicable to the insurer. For
32 purposes of this subdivision, "the total investment of the insurer"
33 includes: (A) Any direct investment by the insurer in an asset, and (B)
34 the insurer's proportionate share of any investment in an asset by any
35 subsidiary or affiliate of the insurer, which shall be calculated by
36 multiplying the amount of the subsidiary's or affiliate's investment by
37 the percentage of the ownership of such subsidiary or affiliate; and (3)
38 with the approval of the commissioner, invest any greater amount in
39 common stock, preferred stock, debt obligations or other securities of
40 one or more subsidiaries or affiliates, provided after such investment
41 the insurer's surplus as regards policyholders will be reasonable in
42 relation to the insurer's outstanding liabilities and adequate to its
43 financial needs.

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

49 (c) With respect to the activities conducted by a domestic insurer's
50 subsidiaries or affiliates, the commissioner shall have the power to: (1)

51 Order said company to curtail the conduct of any activity if he finds,
52 after notice and opportunity to be heard, that such activity is not
53 lawful or is against public policy or that the continuation of such
54 activity is materially adverse to the interests of the insurer's
55 policyholders; and (2) require separate books, accounts and records for
56 such classes of activities of the insurance company subsidiary or
57 affiliate as he shall determine, which books, accounts and records shall
58 be so maintained as to disclose clearly and accurately the nature and
59 details of such activities. The commissioner may determine that an
60 activity is materially adverse to policyholders if he finds that
61 subsidiaries or affiliates are being used to avoid the quantitative
62 limitations directly applicable to insurers under section 38a-102c.

63 Sec. 2. Subdivision (2) of subsection (a) of section 38a-226c of the
64 2006 supplement to the general statutes is repealed and the following
65 is substituted in lieu thereof (*Effective October 1, 2006*):

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

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

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

79 Sec. 3. Subsection (d) of section 38a-478n of the 2006 supplement to
80 the general statutes is repealed and the following is substituted in lieu
81 thereof (*Effective from passage*):

82 (d) (1) Not later than five business days after receiving a written
83 request from the commissioner, enrollee or any provider acting on
84 behalf of an enrollee with the enrollee's consent, a managed care
85 organization or health insurer whose enrollee is the subject of an
86 appeal shall provide to the commissioner, enrollee or any provider
87 acting on behalf of an enrollee with the enrollee's consent, written
88 verification of whether the enrollee's plan is fully insured, self-funded,
89 or otherwise funded. If the plan is a fully insured plan or a self-insured
90 governmental plan, the managed care organization or health insurer
91 shall send: (A) Written certification to the commissioner or reviewing
92 entity, as determined by the commissioner, that the benefit or service
93 subject to the appeal is a covered benefit or service; (B) a copy of the
94 entire policy or contract between the enrollee and the managed care
95 organization or health insurer, except that with respect to a self-
96 insured governmental plan, (i) the managed care organization shall
97 notify the plan sponsor, and (ii) the plan sponsor shall send, or require
98 the managed care organization to send, such copy; or (C) written
99 certification that the policy or contract is accessible to the review entity
100 electronically and clear and simple instructions on how to
101 electronically access the policy or contract.

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

116 determination to reimburse the department for the expenses related to
117 the appeal, including, but not limited to, expenses incurred by the
118 review entity.

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

122 (a) Nothing in sections 38a-478 to 38a-478o, inclusive, as amended,
123 shall be construed to apply to the arrangements of managed care
124 organizations offered to individuals covered under self-insured [health
125 plans] employee welfare benefit plans established pursuant to the
126 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-102d
Sec. 2	<i>October 1, 2006</i>	38a-226c(a)(2)
Sec. 3	<i>from passage</i>	38a-478n(d)
Sec. 4	<i>from passage</i>	38a-478s(a)

Statement of Purpose:

To make minor and other revisions to the insurance statutes.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]