General Assembly

Raised Bill No. 7262

January Session, 2007

LCO No. **3891**

03891_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT REVISING VARIOUS INSURANCE STATUTES.

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

Section 1. Section 38a-53 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) Each domestic insurance company or health care center **[**doing business in this state**]** shall, annually, on or before the first day of March, **[**render**]** submit to the commissioner, and electronically to the National Association of Insurance Commissioners, a true and complete report, signed and sworn to by its president or a vice president, and secretary or an assistant secretary, of its financial condition on the thirty-first day of December next preceding, prepared in accordance with the National Association of Insurance Commissioners annual statement instructions handbook and following those accounting procedures and practices prescribed by the National Association of Insurance Commissioners accounting practices and procedures manual, subject to any deviations in form and detail as may be prescribed by the commissioner. An electronically filed report in accordance with section 38a-53a that is timely submitted to the National Association of Insurance Commissioners does not exempt a

domestic insurance company or health care center from timely filing a true and complete paper copy with the commissioner.

(b) Each foreign insurance company doing business in this state shall, annually, on or before the first day of March, submit to the commissioner, by electronically filing with the National Association of Insurance Commissioners, a true and complete report, signed and sworn to by its president or a vice president, and secretary or an assistant secretary, of its financial condition on the thirty-first day of December next preceding, prepared in accordance with the National Association of Insurance Commissioners annual statement instructions handbook and following those accounting procedures and practices prescribed by the National Association of Insurance Commissioners accounting practices and procedures manual, subject to any deviations in form and detail as may be prescribed by the commissioner. An electronically filed report in accordance with section 38a-53a that is timely submitted to the National Association of Commissioners is deemed to have been submitted to the commissioner in accordance with this section.

[(b)**]** (c) In addition to such annual report, the commissioner, when he deems it necessary, may require any insurance company or health care center doing business in this state to file financial statements on a quarterly basis. An electronically filed true and complete report filed in accordance with section 38a-53a that is timely filed with the National Association of Insurance Commissioners shall be deemed to have been submitted to the commissioner in accordance with the provisions of this section.

[(c)**]** (d) In addition to such annual report and the quarterly report required under subsection **[**(b)**]** (c) of this section, the commissioner, whenever the commissioner determines that more frequent reports are required because of certain factors or trends affecting companies writing a particular class or classes of business or because of changes in the company's management or financial or operating condition, may

require any insurance company or health care center doing business in this state to file financial statements on other than an annual or quarterly basis.

[(d)**]** (e) Any insurance company or health care center doing business in this state which fails to file any report or statement required under this section shall pay a late filing fee of one hundred dollars per day for each day from the due date of such report or statement to the date of filing.

[(e)**]** (f) Each insurance company or health care center doing business in this state shall include in all reports required to be filed with the commissioner under this section a certification by an actuary or reserve specialist of all reserve liabilities prepared in accordance with regulations which shall be adopted by the commissioner in accordance with chapter 54. The regulations shall: (1) Specify the contents and scope of the certification; (2) provide for the availability to the commissioner of the workpapers of the actuary or loss reserve specialist; and (3) provide for exemptions to the companies or centers from compliance with the requirements of this subsection. The commissioner shall maintain, as confidential, all workpapers of the actuary or loss reserve specialist and the actuarial report and actuarial opinion summary provided in support of the certification. Such workpapers, reports and summaries shall not be subject to subpoena or disclosure under the Freedom of Information Act, as defined in section 1-200.

Sec. 2. Section 38a-54 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) **[**On or after December 31, 1990, each**]** Each domestic insurance company, health care center or fraternal benefit society doing business in this state shall have an annual audit conducted by an independent certified public accountant and shall annually file an audited financial report with the commissioner, and electronically to the National Association of Insurance Commissioners on or before the first day of

June for the year ending the preceding December thirty-first. An electronically filed true and complete report timely submitted to the National Association of Insurance Commissioners does not exempt a domestic insurance company or health care center from timely filing a true and complete paper copy to the commissioner.

(b) Each foreign insurance company or fraternal benefit society doing business in this state shall have an annual audit conducted by an independent certified public accountant and shall annually file an audited financial report with the commissioner, and electronically to the National Association of Insurance Commissioners, on or before June first for the year ending the preceding December thirty-first. An electronically filed true and complete report timely submitted to the National Association of Insurance Commissioners shall be deemed to have been submitted to the commissioner in accordance with the provisions of this section.

[(b)**]** (c) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 to: (1) Specify the scope of the examination required by this section; (2) specify the contents and scope of the annual audited financial report, provided such report shall include all incurred losses; (3) provide for the review of the controls; (4) provide for the availability to the commissioner of the workpapers of the certified public accountant; and (5) provide exemptions from compliance with the requirements of this section.

Sec. 3. Subdivision (8) of section 38a-175 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

[(8) "Health care" includes, but shall not be limited to, the following: Medical, surgical and dental care provided through licensed practitioners, including any supporting and ancillary personnel, services and supplies; physical therapy service provided through licensed physical therapists upon the prescription of a physician; psychological examinations provided by registered psychologists;

optometric service provided by licensed optometrists; hospital service, both inpatient and outpatient; convalescent institution care and nursing home care; nursing service provided by a registered nurse or by a licensed practical nurse; home care service of all types required for the health of a person; rehabilitation service required or desirable for the health of a person; preventive medical services of all and any types; furnishing necessary appliances, drugs, medicines and supplies; educational services for the health and well-being of a person; ambulance service; and any other care, service or treatment related to the prevention or treatment of disease, the correction of defects and the maintenance of the physical and mental well-being of human beings. Any diagnosis and treatment of diseases of human beings required for health care as defined in this section, if rendered, shall be under the supervision and control of the providers.**]**

(8) "Health care" means a range of services which enrollees might reasonably require for diagnosis and treatment of illness, injury or disease including as a minimum, but not limited to, the following medical and surgical services provided through licensed practitioners including any supporting and ancillary personnel, any supporting and ancillary services and supplies, physician services, hospitalization, laboratory, x-ray, preventive services and in-network and out-of-network emergency services.

Sec. 4. Subdivision (9) of section 38a-175 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

[(9) "Health care center" means either: (A) A person, including a profit or a nonprofit corporation organized under the laws of this state for the purpose of carrying out the activities and purposes set forth in subsection (b) of section 38a-176, at the expense of the health care center, including the providing of health care, as herein defined, to members of the community, including subscribers to one or more plans under an agreement entitling such subscribers to health care in

consideration of a basic advance or periodic charge and shall include a health maintenance organization, or (B) a line of business conducted by an organization that is formed, pursuant to the laws of this state for the purposes of, but not limited to, carrying out the activities and purposes set forth in subsection (b) of section 38a-176.**]**

(9) "Health care center" means any person who (A) provides either directly or through arrangements with other persons, health care to enrollees on a fixed prepayment basis; (B) provides either directly or through arrangements with other persons, basic health care; and (C) is responsible for the availability, accessibility and quality of the health care provided or arranged.

Sec. 5. Section 38a-176 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

[(a)**]** Each such health care center shall be governed by sections 38a-175 to 38a-192, inclusive, and by the other applicable laws of the state to the extent not inconsistent with the provisions of said sections.

[(b) The nature of the activities to be conducted and the purposes to be carried out by a health care center include, but are not limited to: (1) Establishing, maintaining and operating facilities whereby health care, as hereinbefore defined, may be provided at the expense of the health care center; (2) providing health care directly by its health care center employees who, when required by law, shall be duly licensed to render such service or by agreement or by indemnity arrangement with any hospital, hospital service corporation, medical service corporation, medical group clinic or person qualified and licensed to render any health care service or by both methods; (3) entering into agreements with any governmental agency, or any provider for the training of personnel under the direction of persons licensed to practice any healing art; (4) establishing, operating and maintaining a medical service center, clinic or any such other facility as shall be necessary for the prevention, study, diagnosis and treatment of human ailments and injuries and to promote medical, surgical, dental and

general health education, scientific education, research and learning; (5) marketing, enrolling and administering a health care plan; (6) contracting with insurers licensed in this state, including hospital and medical service corporations; (7) offering, in addition to health services, benefits covering out-of-area or emergency services; (8) providing health services not included in the health care plan on a fee-for-service basis; and (9) entering into contracts in furtherance of the purposes of sections 38a-175 to 38a-192.**]**

Sec. 6. Subsection (a) of section 38a-226c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) All utilization review companies shall meet the following minimum standards:

(1) Each utilization review company shall maintain and make available procedures for providing notification of its determinations regarding certification in accordance with the following:

(A) Notification of any prospective determination by the utilization review company shall be mailed or otherwise communicated to the provider of record or the enrollee or other appropriate individual within two business days of the receipt of all information necessary to complete the review, provided any determination not to certify an admission, service, procedure or extension of stay shall be in writing. After a prospective determination that authorizes an admission, service, procedure or extension of stay has been communicated to the appropriate individual, based on accurate information from the provider, the utilization review company may not reverse such determination if such admission, service, procedure or extension of stay has taken place in reliance on such determination.

(B) Notification of a concurrent determination shall be mailed or otherwise communicated to the provider of record within two business days of receipt of all information necessary to complete the review or,

provided all information necessary to perform the review has been received, prior to the end of the current certified period and provided any determination not to certify an admission, service, procedure or extension of stay shall be in writing.

(C) The utilization review company shall not make a determination not to certify based on incomplete information unless it has clearly indicated, in writing, to the provider of record or the enrollee all the information that is needed to make such determination.

(D) Notwithstanding subparagraphs (A) to (C), inclusive, of this subdivision, the utilization review company may give authorization orally, electronically or communicated other than in writing. If the determination is an approval for a request, the company shall provide a confirmation number corresponding to the authorization.

(E) Except as provided in subparagraph (F) of this subdivision with respect to a final notice, each notice of a determination not to certify an admission, service, procedure or extension of stay shall include in writing (i) the principal reasons for the determination, (ii) the procedures to initiate an appeal of the determination or the name and telephone number of the person to contact with regard to an appeal pursuant to the provisions of this section, and (iii) the procedure to appeal to the commissioner pursuant to section 38a-478n.

(F) Each notice of a final determination not to certify an admission, service, procedure or extension of stay shall include in writing (i) the principal reasons for the determination, (ii) a statement that all internal appeal mechanisms have been exhausted, and (iii) a copy of the application and procedures prescribed by the commissioner for filing an appeal to the commissioner pursuant to section 38a-478n.

(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 healing arts, as defined in section 38a-175, as amended by this act.

(3) The process established by each utilization review company may include a reasonable period within which an appeal **[**must**]** shall be filed to be considered.

(4) Each utilization review company shall also provide for an expedited appeals process for emergency or life threatening situations. Each utilization review company shall complete the adjudication of such expedited appeals within two business days of the date the appeal is filed and all information necessary to complete the appeal is received by the utilization review company.

(5) Each utilization review company shall utilize written clinical criteria and review procedures which are established and periodically evaluated and updated with appropriate involvement from practitioners.

(6) Physicians, nurses and other licensed health professionals making utilization review decisions shall have current licenses from a state licensing agency in the United States or appropriate certification from a recognized accreditation agency in the United States, provided, any final determination not to certify an admission, service, procedure or extension of stay for an enrollee within this state, except for a claim brought pursuant to chapter 568, shall be made by a physician, nurse

or other licensed health professional under the authority of a physician, nurse or other licensed health professional who has a current Connecticut license from the Department of Public Health.

(7) In cases where an appeal to reverse a determination not to certify is unsuccessful, each utilization review company shall assure that a practitioner in a specialty related to the condition is reasonably available to review the case. When the reason for the determination not to certify is based on medical necessity, including whether a treatment is experimental or investigational, each utilization review company shall have the case reviewed by a physician who is a specialist in the field related to the condition that is the subject of the appeal. Any such review, except for a claim brought pursuant to chapter 568, that upholds a final determination not to certify in the case of an enrollee within this state shall be conducted by such practitioner or physician under the authority of a practitioner or physician who has a current Connecticut license from the Department of Public Health. The review shall be completed within thirty days of the request for review. The utilization review company shall be financially responsible for the review and shall maintain, for the commissioner's verification, documentation of the review, including the name of the reviewing physician.

(8) Except as provided in subsection (e) of this section, each utilization review company shall make review staff available by toll-free telephone, at least forty hours per week during normal business hours.

(9) Each utilization review company shall comply with all applicable federal and state laws to protect the confidentiality of individual medical records. Summary and aggregate data shall not be considered confidential if it does not provide sufficient information to allow identification of individual patients.

(10) Each utilization review company shall allow a minimum of twenty-four hours following an emergency admission, service or

procedure for an enrollee or his representative to notify the utilization review company and request certification or continuing treatment for that condition.

(11) No utilization review company may give an employee any financial incentive based on the number of denials of certification such employee makes.

(12) Each utilization review company shall annually file with the commissioner:

(A) The names of all managed care organizations, as defined in section 38a-478, that the utilization review company services in Connecticut;

(B) Any utilization review services for which the utilization review company has contracted out for services and the name of such company providing the services;

(C) The number of utilization review determinations not to certify an admission, service, procedure or extension of stay and the outcome of such determination upon appeal within the utilization review company. Determinations related to mental or nervous conditions, as defined in section 38a-514, shall be reported separately from all other determinations reported under this subdivision; and

(D) The following information relative to requests for utilization review of mental health services for enrollees of fully insured health benefit plans or self-insured or self-funded employee health benefit plans, separately and by category: (i) The reason for the request, including, but not limited to, an inpatient admission, service, procedure or extension of inpatient stay or an outpatient treatment, (ii) the number of requests denied by type of request, and (iii) whether the request was denied or partially denied.

(13) Any utilization review decision to initially deny services shall be made by a licensed health professional.

Sec. 7. Subsection (b) of section 38a-465m of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(b) Such regulations may establish standards for evaluating reasonableness of payments under viatical settlement contracts. **[**for persons who are terminally or chronically ill.**]** Such regulations may include, but are not limited to, the regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise or bequest of a benefit under a life insurance policy.

Sec. 8. Subsection (d) of section 38a-495c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(d) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity in the state issuing Medicare supplement policies or certificates for plan "A", "B" or "C", or any combination thereof, to persons eligible for Medicare by reason of age, shall offer for sale the same such policies or certificates to persons eligible for Medicare **[**by reason of disability**]** for reasons other than age including, but not limited to, disability and end stage renal disease.

Sec. 9. Section 38a-614 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

Reports shall be filed and synopses of annual statements shall be published in accordance with the provisions of this section.

(1) Every domestic society transacting business in this state shall annually, on or before the first day of March, unless for cause shown such time has been extended by the commissioner, file with the commissioner, and electronically to the National Association of Insurance Commissioners, a true and complete statement of its financial condition, transactions and affairs for the preceding calendar

year and pay a fee of ten dollars for filing the same. The statement shall be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the commissioner. An electronically filed true and complete report filed in accordance with section 38a-53a that is timely submitted to the National Association of Insurance Commissioners does not exempt a domestic insurance company or health care center from timely filing a true and complete paper copy with the commissioner.

(2) Every foreign society transacting business in this state shall annually, on or before the first day of March, unless for cause shown such time has been extended by the commissioner, file with the commissioner, and electronically to the National Association of Insurance Commissioners, a true and complete statement of its financial condition, transactions and affairs for the preceding calendar year and pay a fee of ten dollars for filing the same. The statement shall be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the commissioner. An electronically filed true and complete report filed in accordance with section 38a-53a that is timely submitted to the National Association of Insurance Commissioners shall be deemed to have been submitted to the commissioner in accordance with this section.

[(2)**]** (3) A synopsis of its annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall be printed and mailed to each benefit member of the society not later than the first day of June of each year, or, in lieu thereof, such synopsis may be published in the society's official publication.

[(3)**]** (4) As part of the annual statement herein required, each society shall, on or before the first day of March, file with the commissioner a valuation of its certificates in force on December

thirty-first last preceding, provided the commissioner may, in his discretion for cause shown, extend the time for filing such valuation for not more than two calendar months. Such report of valuation shall show, as reserve liabilities, the difference between the present midyear value of the promised benefits provided in the certificates of such society in force and the present midyear value of the future net premiums as the same are in practice actually collected, not including therein any value for the right to make extra assessments and not including any amount by which the present midyear value of future net premiums exceeds the present midyear value of promised benefits on individual certificates. At the option of any society, in lieu of the above, the valuation may show the net tabular value. Such net tabular value as to certificates issued prior to January 1, 1959, shall be determined in accordance with the provisions of law applicable prior to January 1, 1958, and as to certificates issued on or after January 1, 1959, shall not be less than the reserves determined according to the Commissioners' Reserve Valuation method as hereinafter defined. If the premium charge is less than the tabular net premium according to the basis of valuation used, an additional reserve equal to the present value of the deficiency in such premiums shall be set up and maintained as a liability. The reserve liabilities shall be properly adjusted if the midyear or tabular values are not appropriate.

[(4)**]** (5) Reserves according to the Commissioners' Reserve Valuation method, for the life insurance and endowment benefits of certificates providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such certificates over the then present value of any future modified net premiums therefor. The modified net premiums for any such certificate shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the certificate, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the certificate and the excess of **[**(a)**]** (A) over

[(b)**]** (B), as follows: **[**(a)**]** (A) A net level premium equal to the present value, at the date of issue, of such benefits provided for after the first certificate year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such certificate on which a premium falls due; provided such net level annual premium shall not exceed the net level annual premium on the nineteen year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of such certificate; and **[**(b)**]** (B) a net one-year term premium for such benefits provided for in the first certificate year. Reserves according to the Commissioners' Reserve Valuation method for **[**(1)**]** (i) life insurance benefits for varying amounts of benefits or requiring the payment of varying premiums, **[**(2)**]** (ii) annuity and pure endowment benefits, **[**(3)**]** (iii) disability and accidental death benefits in all certificates and contracts, and **[**(4)**]** (iv) all other benefits except life insurance and endowment benefits shall be calculated by a method consistent with the principles of this **[**subsection**]** subdivision.

[(5)**]** (6) The present value of deferred payments due under incurred claims or matured certificates shall be deemed a liability of the society and shall be computed upon mortality and interest standards prescribed in **[**subsection (6)**]** subdivision (7) of this section.

[(6)**]** (7) Such valuation and underlying data shall be certified by a competent actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society. The minimum standards of valuation for certificates issued prior to January 1, 1959, shall be those provided by the law applicable immediately prior to January 1, 1958, but not lower than the standards used in the calculating of rates for such certificates. The minimum standard of valuation for certificates issued after January 1, 1959, shall be three and one-half per cent interest and the following tables: **[**(a)**]** (A) For certificates of life insurance, American Men Ultimate Table of Mortality, with Bowerman's or Davis' Extension thereof or, with the consent of the Insurance Commissioner, the Commissioner's 1941

Standard Ordinary Mortality Table or the Commissioner's 1941 Standard Industrial Table of Mortality, or the Commissioners' 1958 Standard Ordinary Mortality Table, except that, with the approval of the commissioner, the valuation of contracts on female risks may be calculated, at the option of the society, according to an age not more than three years younger than the actual age of the insured; **[**(b)**]** (B) for annuity certificates, including life annuities provided or available under optional modes of settlement in such certificates, the 1937 Standard Annuity Table; **[**(c)**]** (C) for disability benefits issued in connection with life benefit certificates, Hunter's Disability Table, which, for active lives, shall be combined with a mortality table permitted for calculating the reserves on life insurance certificates, except that the table known as Class III Disability Table (1926), modified to conform to the contractual waiting period, shall be used in computing reserves for disability benefits under a contract which presumes that total disability shall be considered to be permanent after a specified period; **[**(d)**]** (D) for accidental death benefits issued in connection with life benefit certificates, the Inter-Company Double Indemnity Mortality Table combined with a mortality table permitted for calculating the reserves for life insurance certificates; and **[**(e)**]** (E) for noncancellable accident and health benefits, the Class III Disability Table (1926) with conference modifications or, with the consent of the commissioner, tables based upon the society's own experience. The commissioner may, in **[**his**]** the commissioner's discretion, accept other standards for valuation if **[**he**]** the commissioner finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard herein prescribed. The commissioner may, in his or her discretion, vary the standards of mortality applicable to all certificates of insurance on substandard lives or other extra hazardous lives by any society authorized to do business in this state. Whenever the mortality experience under all certificates valued on the same mortality table is in excess of the expected mortality according to such table for a period of three consecutive years, the commissioner may require additional

reserves when deemed necessary in his or her judgment on account of such certificates. Any society, with the consent of the insurance commissioner of the state of domicile of the society and under such conditions, if any, which **[**he**]** the commissioner may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any insured member shall not be affected thereby.

[(7)**]** (8) A society neglecting to file the annual statement in the form and within the time provided by this section shall forfeit one hundred dollars for each day during which such neglect continues, and, upon notice by the commissioner to that effect, its authority to do business in this state shall cease while such default continues.

[(8)**]** (9) Notwithstanding the provisions of this section, a society may, with the approval of the Insurance Commissioner, use the standards for valuation and nonforfeiture authorized by the provisions of sections 38a-61, 38a-77, 38a-78, 38a-81, 38a-82, 38a-284, 38a-287, 38a-430 to 38a-454, inclusive, and 38a-458.

Sec. 10. Section 38a-177 of the general statutes is repealed. (*Effective October 1, 2007*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2007*	38a-53
Sec. 2	*October 1, 2007*	38a-54
Sec. 3	*October 1, 2007*	38a-175(8)
Sec. 4	*October 1, 2007*	38a-175(9)
Sec. 5	*October 1, 2007*	38a-176
Sec. 6	*October 1, 2007*	38a-226c(a)
Sec. 7	*October 1, 2007*	38a-465m(b)
Sec. 8	*October 1, 2007*	38a-495c(d)
Sec. 9	*October 1, 2007*	38a-614
Sec. 10	*October 1, 2007*	Repealer section

Statement of Purpose:

To provide for electronic-only filing of annual and quarterly financial statements by a foreign insurer to be made instead of requiring hard copy; to provide for electronic-only filing of annual financial audits by a foreign insurer to be made instead of requiring hard copy; to revise the "health care" definition to more accurately define the range and categories of health care services to be provided through the health care centers; to revise the definition of "health care center" to reflect current models using individual practice arrangements and carve-outs of ancillary services and to bring all prepaid arrangements rendering health care services by any health care professional for treatment of injury, illness or disease under the regulatory authority of the Insurance Department; to amend purposes and activities of health care centers which are no longer required as a result of amendments to sections 38a-175 and 38a-176 of the general statutes; to repeal section 38a-177 of the general statutes which is an unnecessary provision; to provide authority to adopt regulations for viaticals for other than terminally ill persons; to harmonize the eligibility requirements for Medicare supplement policies to include not only age and disability but also end stage rental disease; and to provide for electronic-only filing of annual and quarterly financial statements by foreign fraternal societies to be made instead of requiring hard copy.

[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.]