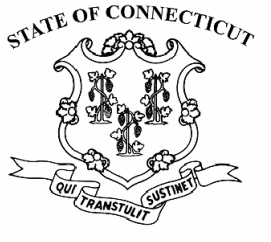

Substitute House Bill No. 5158

Public Act No. 08-147

AN ACT MAKING CHANGES TO THE INSURANCE STATUTES.

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

Section 1. Section 38a-85 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2008*):

(a) Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of subsection (b), (c), (d), (e) or (f) of this section. If credit is allowed on the basis of meeting the requirements of subsection (d) or (e) of this section, the requirements of subsection (g) of this section shall also be met.

(b) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is licensed to transact insurance or reinsurance in this state.

(c) (1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is accredited as a reinsurer in this state. No credit shall be allowed a domestic ceding insurer, if the assuming insurers' accreditation has been revoked by the commissioner after notice and hearing. An accredited reinsurer is one **[**which (1)**]** that (A)

files with the commissioner evidence of its submission to this state's jurisdiction, **[**(2)**]** (B) submits to this state's authority to examine its books and records, **[**(3)**]** (C) is licensed to transact insurance or reinsurance in at least one state, or in the case of a United States branch of an alien assuming insurer is entered through and licensed to transact insurance or reinsurance in at least one state, and **[**(4)**]** (D) files annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement, and either **[**(A)**]** (i) maintains a surplus as regards policyholders in an amount which is not less than twenty million dollars and whose accreditation has not been denied by the commissioner within ninety days of its submission, or **[**(B)**]** (ii) maintains a surplus as regards policyholders in an amount less than twenty million dollars and whose accreditation has been approved by the commissioner.

(2) Each accredited reinsurer 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 Insurance Commissioners is deemed to have been submitted to the commissioner in accordance with this subdivision.

(d) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is domiciled and licensed in, or in the case of a United States branch of an alien assuming insurer is entered through, a state which employs standards regarding credit for reinsurance substantially similar to those applicable in this state and the assuming insurer or United States branch of an alien assuming insurer (1) maintains a surplus as regards policyholders in an amount not less than twenty million dollars and (2) submits to the authority of this state to examine its books and records. The requirement of subdivision (1) of this subsection does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(e) (1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which maintains a trust fund in a qualified United States financial institution, as defined in subsection (b) of section 38a-87, for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the commissioner information substantially the same as that required to be reported on in the National Association of Insurance Commissioners' Annual Statement form by licensed insurers to enable the commissioner to determine the sufficiency of the trust fund. In the case of a single assuming insurer, the trust shall consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than twenty million dollars. In the case of a group including incorporated and individual unincorporated underwriters, the trust shall consist of a trusteed account representing the group's liabilities attributable to business written in the United States and, in addition, the group shall maintain a trusteed surplus of which one hundred million dollars shall be held jointly for the benefit of United States ceding insurers of any

member of the group; the incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members; and the group shall make available to the commissioner an annual certification of the solvency of each underwriter by the group's domiciliary regulator and its independent public accountants.

(2) Such trust shall be established in a form approved by the commissioner. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in the trustees of the trust for its United States policyholders and ceding insurers, their assigns and successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the commissioner. The trust described herein must remain in effect for as long as the assuming insurer shall have outstanding obligations due under the reinsurance agreements subject to the trust.

(3) No later than the first day of March of each year the trustees of the trust shall report to the commissioner in writing setting forth the balance of the trust and listing the trust's investments at the end of the preceding year and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December thirty-first.

(4) Each assuming insurance company shall, on or before the first day of March, 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 of the trust 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 an assuming insurance company from timely filing a true and complete paper copy with the commissioner.

(f) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of subsection (b), (c), (d) or (e) of this section but only with respect to the insurance of risks located in jurisdictions where such reinsurance is required by applicable law or regulation of that jurisdiction.

(g) If the assuming insurer is not licensed or accredited to transact insurance or reinsurance in this state, the credit permitted by subsections (d) and (e) of this section shall not be allowed unless the assuming insurer agrees (1) that in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall (A) submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, (B) comply with all requirements necessary to give such court jurisdiction and (C) abide by the final decision of such court or any appellate court in the event of an appeal, and (2) to designate the commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding company. This provision is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if such an obligation

is created in the agreement.

Sec. 2. Subparagraph (B) of subdivision (2) of subsection (a) of section 38a-92m of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2008*):

(B) An insurer licensed in this state to transact surety insurance or reinsurance, but not financial guaranty insurance pursuant to sections 38a-92 to 38a-92n, inclusive, or accredited as a reinsurer in this state as provided in subdivision (1) of subsection (c) of section 38a-85, as amended by this act, if the insurer or reinsurer meets all of the following criteria: (i) Has and maintains combined capital and surplus of at least fifty million dollars; (ii) establishes and maintains the reserves required in section 38a-92c, except that if the reinsurance agreement is nonproportional, the contribution to the contingency reserve shall be equal to fifty per cent of the quarterly written insurance premium; (iii) complies with the provisions of subsection (b) of section 38a-92i, except that its maximum aggregate assumed total net liability shall be one-half that permitted for a financial guaranty insurance corporation. For the purpose of determining compliance, the reinsurer, unless at the time of cession and thereafter it is rated in one of the two top generic rating classifications by a securities rating agency acceptable to the commissioner, shall be limited to using ten per cent of its capital and surplus in making this calculation; (iv) complies with the provisions of section 38a-92j; and (v) assumes, together with all other reinsurers subject to this subparagraph, less than fifty per cent of the ceding insurer's total liability after deducting any reinsurance ceded to any insurers pursuant to subparagraph (A) of this subdivision.

Sec. 3. Subsection (a) of section 38a-53 of the 2008 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2008*):

(a) (1) Each domestic insurance company or health care center shall, annually, on or before the first day of March, 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.

(2) Each accredited reinsurer, as defined in subsection (c) of section 38a-85, as amended by this act, and assuming insurance company, as provided in section 38a-85, as amended by this act, shall file an annual report in accordance with the provisions of section 38a-85, as amended by this act.

Sec. 4. Section 38a-253 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2008*):

(a) **[**Any**]** Each risk retention group not domiciled in this state **[**which**]** that is doing business in this state shall submit to the Insurance Commissioner: (1) A copy of the group's financial statement submitted to its state of domicile, which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist;

(2) a copy of each examination of the risk retention group as certified by the commissioner or public official conducting the examination; (3) upon request by the commissioner, a copy of any audit performed with respect to the risk retention group; and (4) such information as may be required to verify that it satisfies the definitional requirements of subdivision (11) of section 38a-250.

(b) Each risk retention group 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 as submitted to its state of domicile.

[(b) Any**]** (c) Each risk retention group **[**must**]** shall submit to an examination by the Insurance Commissioner to determine its financial condition if the commissioner of the jurisdiction in which the group is chartered has not initiated an examination or does not initiate an examination within sixty days after a request by the Insurance Commissioner of this state. Any such examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the National Association of Insurance Commissioners' Examiner Handbook.

Sec. 5. Section 38a-469 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2008*):

As used in this title, unless the context otherwise requires or a different meaning is specifically prescribed, "health insurance" policy means insurance providing benefits due to illness or injury, resulting in loss of life, loss of earnings, or expenses incurred, and includes the following types of coverage: (1) Basic hospital expense coverage; (2)

basic medical-surgical expense coverage; (3) hospital confinement indemnity coverage; (4) major medical expense coverage; (5) disability income protection coverage; (6) accident only coverage; (7) long term care coverage; (8) specified accident coverage; (9) Medicare supplement coverage; (10) limited benefit health coverage; (11) hospital or medical service plan contract; (12) hospital and medical coverage provided to subscribers of a health care center; (13) specified disease coverage; (14) TriCare supplement coverage.

Sec. 6. Section 38a-477a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2008*):

The Insurance Commissioner shall provide written or electronic notification to each insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or any other entity that delivers or issues for delivery, in this state, any individual or group health insurance plan (1) of any benefits required to be provided in such plan pursuant to this chapter, or of any modification to such benefits on or after October 1, 2006, at least thirty days prior to the date such benefits or modification becomes effective, and (2) instructing such company, society, corporation, center or other entity to submit to the Insurance Commissioner, prior to the date such benefits or modification becomes effective or upon the renewal date of the plan, any necessary policy forms, in accordance with the provisions of section 38a-481 or 38a-513, as applicable, that reflect such benefits or modification.

Sec. 7. Subsection (d) of section 38a-478n of the 2008 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2008*):

(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-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 sixty-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. 8. Section 38a-497 of the 2008 supplement to the general statutes, as amended by section 16 of public act 07-185 and sections 64 and 69 of public act 07-2 of the June special session, is repealed and the following is substituted in lieu thereof (*Effective January 1, 2009*):

Every individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469, as amended by this act, delivered, issued for delivery, amended or renewed in this state on or after January 1, 2009, shall provide that coverage of a child shall terminate no earlier than the policy anniversary date on or after whichever of the following occurs first, the date on which the child: **[**marries, or**]** Marries; ceases to be a resident of the state; becomes covered under a group health plan through the dependent's own employment; or attains the age of twenty-six. **[**as long as the child is a resident of the state except for full-time attendance at an out-of-state accredited institution of higher education or resides out of state with a custodial parent pursuant to a child custody determination, as defined in section 46b-115a**]** The residency requirement shall not apply to dependent children under nineteen years of age or full-time students attending an accredited institution of higher education.

Sec. 9. Section 38a-554 of the 2008 supplement to the general statutes, as amended by section 17 of public act 07-185 and sections 65 and 69 of public act 07-2 of the June special session, is repealed and the following is substituted in lieu thereof (*Effective January 1, 2009*):

(a) The plan shall be one under which the individuals eligible to be covered include: (1) Each eligible employee; (2) the spouse of each eligible employee, who shall be considered a dependent for the

purposes of this section; and (3) unmarried children **[**residing in the state,**]** who are under twenty-six years of age.

(b) The plan shall provide the option to continue coverage under each of the following circumstances until the individual is eligible for other group insurance, except as provided in subdivisions (3) and (4) of this subsection: (1) Notwithstanding any provision of this section, upon layoff, reduction of hours, leave of absence, or termination of employment, other than as a result of death of the employee or as a result of such employee's "gross misconduct" as that term is used in 29 USC 1163(2), continuation of coverage for such employee and such employee's covered dependents for the periods set forth for such event under federal extension requirements established by the federal Consolidated Omnibus Budget Reconciliation Act of 1985, **[**(P.L. 99-272)**]** P.L. 99-272, as amended from time to time, **[**(COBRA),**]** except that if such reduction of hours, leave of absence or termination of employment results from an employee's eligibility to receive Social Security income, continuation of coverage for such employee and such employee's covered dependents until midnight of the day preceding such person's eligibility for benefits under Title XVIII of the Social Security Act; (2) upon the death of the employee, continuation of coverage for the covered dependents of such employee for the periods set forth for such event under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, **[**(P.L. 99-272)**]** P.L. 99-272, as amended from time to time; **[**, (COBRA);**]** (3) regardless of the employee's or dependent's eligibility for other group insurance, during an employee's absence due to illness or injury, continuation of coverage for such employee and such employee's covered dependents during continuance of such illness or injury or for up to twelve months from the beginning of such absence; (4) regardless of an individual's eligibility for other group insurance, upon termination of the group plan, coverage for covered individuals who were totally disabled on the date of termination shall be

continued without premium payment during the continuance of such disability for a period of twelve calendar months following the calendar month in which the plan was terminated, provided claim is submitted for coverage within one year of the termination of the plan; (5) the coverage of any covered individual shall terminate: (A) As to a child, the plan shall provide the option for said child to continue coverage for the longer of the following periods: (i) At the end of the month following the month in which the child: **[**marries, or**]** Marries; ceases to be a resident of the state; becomes covered under a group health plan through the dependent's own employment; or attains the age of twenty-six. **[**, provided the child is a resident of the state except for full-time attendance at an out-of-state accredited institution of higher education or resides out of state with a custodial parent pursuant to a child custody determination, as defined in section 46b-115a**]** The residency requirement shall not apply to dependent children under nineteen years of age or full-time students attending an accredited institution of higher education. If on the date specified for termination of coverage on a child, the child is unmarried and incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the employee for support and maintenance, the coverage on such child shall continue while the plan remains in force and the child remains in such condition, provided proof of such handicap is received by the carrier within thirty-one days of the date on which the child's coverage would have terminated in the absence of such incapacity. The carrier may require subsequent proof of the child's continued incapacity and dependency but not more often than once a year thereafter, or (ii) for the periods set forth for such child under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, **[**(P.L. 99-272)**]** P.L. 99-272, as amended from time to time; **[**, (COBRA);**]** (B) as to the employee's spouse, at the end of the month following the month in which a divorce, court-ordered annulment or legal separation is obtained, whichever is earlier, except

that the plan shall provide the option for said spouse to continue coverage for the periods set forth for such events under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, **[**(P.L. 99-272)**]** P.L. 99-272, as amended from time to time; **[**, (COBRA);**]** and (C) as to the employee or dependent who is sixty-five years of age or older, as of midnight of the day preceding such person's eligibility for benefits under Title XVIII of the federal Social Security Act; (6) as to any other event listed as a "qualifying event" in 29 USC 1163, as amended from time to time, continuation of coverage for such periods set forth for such event in 29 USC 1162, as amended from time to time, provided such plan may require the individual whose coverage is to be continued to pay up to the percentage of the applicable premium as specified for such event in 29 USC 1162, as amended from time to time. Any continuation of coverage required by this section except subdivision (4) or (6) of this subsection may be subject to the requirement, on the part of the individual whose coverage is to be continued, that such individual contribute that portion of the premium the individual would have been required to contribute had the employee remained an active covered employee, except that the individual may be required to pay up to one hundred two per cent of the entire premium at the group rate if coverage is continued in accordance with subdivision (1), (2) or (5) of this subsection. The employer shall not be legally obligated by sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, to pay such premium if not paid timely by the employee.

Sec. 10. Section 38a-860 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2008*):

(a) Sections 38a-858 to 38a-875, inclusive, shall provide coverage for the policies and contracts specified in subsection (f) of this section: (1) To any person, except for a nonresident certificate holder under a group policy or contract, who is the beneficiary, assignee or payee of

the person covered under subdivision (2) of this subsection, regardless of where the person resides, and (2) any person who is the owner of, or certificate holder under, such policy or contract and in each case who (A) is a resident, or (B) is not a resident, provided (i) the insurer that issued such policy or contract is domiciled in this state, (ii) the state in which the person resides has an association similar to the association created by this section and sections 38a-837, 38a-838, 38a-845, 38a-853, 38a-862, 38a-863, 38a-865 and 38a-866, and (iii) the person is not eligible for coverage by an association in any other state because the insurer was not licensed in the state at the time specified in the state's guaranty association law.

(b) For unallocated annuity contracts specified in subsection (f) of this section, subdivisions (1) and (2) of subsection (a) of this section shall not apply, and except as provided in subsections (d) and (e) of this section, sections 38a-858 to 38a-875, inclusive, shall apply to: (1) Any person who is the owner of the unallocated annuity contract if the contract is issued to, or in connection with, a specific benefit plan whose plan sponsor has its principal place of business in this state; and (2) any person who is the owner of an unallocated annuity contract issued to, or in connection with, government lotteries if the owners are residents.

(c) For structured settlement annuities specified in subsection (f) of this section, subdivisions (1) and (2) of subsection (a) of this section shall not apply, and except as provided in subsections (d) and (e) of this section, sections 38a-858 to 38a-875, inclusive, shall apply to a person who is a payee under a structured settlement annuity, or to a beneficiary of a payee if the payee is deceased, if the payee: (1) Is a resident, regardless of where the contract owner resides, or (2) is not a resident, provided: (A) (i) The contract owner of the structured settlement annuity is a resident, or (ii) the contract owner of the structured settlement annuity is not a resident, but the insurer that

issued the structured settlement annuity is domiciled in this state, and the state in which the contract owner resides has an association similar to the association created by sections 38a-858 to 38a-875, inclusive; and (B) neither the payee, beneficiary or contract owner is eligible for coverage by the association of the state in which the payee, beneficiary or contract owner resides.

(d) Sections 38a-858 to 38a-875, inclusive, shall not provide coverage to: (1) A person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state; or (2) a person covered under subsection (b) of this section, if any coverage is provided by the association of another state to the person.

(e) Sections 38a-858 to 38a-875, inclusive, shall provide coverage to a person who is a resident and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under sections 38a-858 to 38a-875, inclusive, is provided coverage under the laws of any other state, the person shall not be provided coverage under sections 38a-858 to 38a-875, inclusive. In determining the application of the provisions of this subsection in situations where a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary or assignee, sections 38a-858 to 38a-875, inclusive, shall be construed in conjunction with the laws of other states to result in coverage by only one association.

(f) (1) Sections 38a-858 to 38a-875, inclusive shall provide coverage to the persons specified in subsections (a) to (d), inclusive, of this section for direct, nongroup life, health or annuity policies or contracts and supplemental contracts to such policies or contracts, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by said sections. Annuity contracts and certificates under group annuity

contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries and any immediate or deferred annuity contracts. (2) Said sections 38a-858 to 38a-875, inclusive, shall not provide coverage for: (A) Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract holder; (B) any policy or contract of reinsurance, unless assumption certificates have been issued; (C) any portion of a policy or contract to the extent that the rate of interest on which it is based or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value (i) averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, exceeds the rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, whichever is earlier; and (ii) on and after the date on which the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available; (D) any plan or program of an employer, association or similar entity to provide life, health or annuity benefits to its employees or members to the extent that such plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association or similar entity under (i) a multiple employer welfare arrangement as defined in Section 514 of the federal Employee Retirement Income Security Act of 1974, as amended from

time to time; (ii) a minimum premium group insurance plan; or (iii) **[**a stop-loss group insurance plan; or (iv)**]** an administrative services only contract; (E) any stop-loss or excess loss insurance policy or contract providing for the indemnification of or payment to a policy owner, a contract owner, a plan or another person obligated to pay life, health or annuity benefits; (F) any portion of a policy or contract to the extent that it provides dividends, experience rating credits, voting rights or provides that any fees or allowances be paid to any person, including, but not limited to, the policy or contract holder, in connection with the service to or administration of such policy or contract; **[**(F)**]** (G) any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state; **[**(G)**]** (H) any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan; **[**(H)**]** (I) any portion of an unallocated annuity contract that is not issued to, or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery; **[**(I)**]** (J) any subscriber contract issued by a health care center; **[**(J)**]** (K) a contractual agreement that establishes the insurer's obligation by reference to a portfolio of assets that is not owned or possessed by the insurance company; **[**(K)**]** (L) an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including, but not limited to: (i) A claim based on marketing materials; (ii) a claim based on side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements; (iii) a misrepresentation of or regarding policy benefits; (iv) an extra-contractual claim; or (v) a claim for penalties or consequential or incidental damages; **[**(L)**]** (M) a contractual agreement that establishes the member insurer's obligations to provide a book value accounting

guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer; and **[**(M)**]** (N) a portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subparagraph, the interest or change in value determined by using the procedures defined in the policy or contract shall be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and shall not be subject to forfeiture.

(g) The benefits for which the association may become liable shall in no event exceed the lesser of: (1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired insurer, or (2) (A) with respect to any one life, regardless of the number of policies or contracts: (i) Five hundred thousand dollars in life insurance death benefits, but no more than five hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance; (ii) five hundred thousand dollars in health insurance benefits, including, but not limited to, any net cash surrender and net cash withdrawal values; (iii) five hundred thousand dollars in the present value of annuity benefits, including, but not limited to, net cash surrender and net cash withdrawal values; (B) with respect to each individual participating in a governmental retirement plan established under Section 401, 403(b) or 457 of the United States

Internal Revenue Code of 1986, or any subsequent internal revenue code of the United States, as amended from time to time, covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, five hundred thousand dollars in present value annuity benefits, including, but not limited to, net cash surrender and net cash withdrawal values; (C) with respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, five hundred thousand dollars in present value annuity benefits, in the aggregate, including, but not limited to, net cash surrender and net cash withdrawal values, if any, provided in no event shall the association be liable to expend (i) more than the five hundred thousand dollars in the aggregate with respect to any one individual under subparagraphs (A), (B) and (C) of this subdivision, and (ii) with respect to one owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than five million dollars in benefits, regardless of the number of policies and contracts held by the owner; (D) with respect to either (i) one contract owner provided coverage under subparagraph (B) of subdivision (2) of subsection (b) of this section, or (ii) one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in subdivision (2) of subsection (f) of this section, five million dollars in benefits regardless of the number of contracts with respect to the contract owner or plan sponsor, except that in the case where one or more unallocated annuity contracts are covered contracts under sections 38a-858 to 38a-875, inclusive, and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state and in no event shall the association be obligated to cover more than five million dollars in benefits with respect to all such unallocated contracts.

(h) The limits set forth in subsection (g) of this section are limits on the benefits for which the association is obligated before taking into account either the association's subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer that are attributable to covered policies. The costs of the association's obligations under sections 38a-858 to 38a-875, inclusive, may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to the association's subrogation and assignment rights.

(i) In performing its obligation to provide coverage under section 38a-865, the association shall not be required to guarantee, assume, reinsure or perform, or cause to be guaranteed, assumed, reinsured or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that does not materially affect the economic value or economic benefit of the covered policy or contract.

Sec. 11. Section 38a-482b of the 2008 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2008*):

(a) Each individual health insurance policy, subscriber contract or certificate of coverage delivered or issued for delivery in this state on or after January 1, 2008, that provides limited coverage, and any marketing material, application for coverage and enrollment material relative to such policy, contract or certificate, shall include the following statement printed in capital letters in not less than twelve-point bold face type and located in a conspicuous manner on such document:

"THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER

ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS ARE AS FOLLOWS: (INSURER TO SPECIFY SUCH AMOUNTS)."

(b) For the purposes of this section, "limited coverage" means an insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 that contains an annual maximum benefit of less than one hundred thousand dollars **[**or a per service or per condition benefit limit of less than twenty thousand dollars**]** or fixed dollar benefits of less than twenty thousand dollars on any core services. For the purpose of this section, "core services" means medical, surgical and hospital services, including inpatient and outpatient physician, laboratory and imaging services.

Sec. 12. Section 38a-513d of the 2008 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2008*):

(a) No insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, continuing or amending any group health insurance policy in this state on or after January 1, 2008, shall deliver or issue for delivery in this state any policy providing limited coverage to any employer as a replacement for a comprehensive health insurance plan for its employees.

(b) Each group health insurance policy, subscriber contract or certificate of coverage delivered or issued for delivery in this state on or after January 1, 2008, that provides limited coverage, and any

marketing material, application for coverage and enrollment material relative to such policy, contract or certificate, shall include the following statement printed in capital letters in not less than twelve-point bold face type and located in a conspicuous manner on such document:

"THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS ARE AS FOLLOWS: (INSURER TO SPECIFY SUCH AMOUNTS)."

(c) For the purposes of this section, "limited coverage" means an insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 that contains an annual maximum benefit of less than one hundred thousand dollars **[**or a per service or per condition benefit limit of less than twenty thousand dollars**]** or fixed dollar benefits of less than twenty thousand dollars on any core services. For the purpose of this section, "core services" means medical, surgical and hospital services, including inpatient and outpatient physician, laboratory and imaging services.

Sec. 13. Section 38a-432a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The Insurance Commissioner shall adopt regulations, in accordance with chapter 54, to establish (1) standards for the sale or exchange of annuities, as defined in section 38a-1, **[**of the general statutes,**]** to

[senior**]** consumers, and (2) procedures for making recommendations to **[**senior**]** consumers regarding the sale or exchange of an annuity. **[**For purposes of said regulations, "senior consumer" means an individual sixty-five years of age or older, except that in the event of a joint purchase by more than one person, the purchaser shall be considered to be a senior consumer if any of the purchasers is sixty-five years of age or older.**]**

Sec. 14. Section 38a-479aa of the 2008 supplement to the general statutes is amended by adding subsection (n) as follows (*Effective from passage*):

(NEW) (n) The requirements of subsections (h) and (i) of this section shall not apply to a consortium of federally qualified health centers funded by the state, providing services only to recipients of programs administered by the Department of Social Services. The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to establish criteria to certify any such federally qualified health center, including, but not limited to, minimum reserve fund requirements.

Approved June 12, 2008