



House of Representatives

File No. 687

General Assembly

February Session, 2008

(Reprint of File No. 290)

Substitute House Bill No. 5158
As Amended by House Amendment Schedule
"A"

Approved by the Legislative Commissioner
April 18, 2008

AN ACT MAKING CHANGES TO THE INSURANCE STATUTES.

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

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 Section 38a-85 of the general statutes is repealed and the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

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

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

13 (c) (1) Credit shall be allowed when the reinsurance is ceded to an
14 assuming insurer which is accredited as a reinsurer in this state. No

15 credit shall be allowed a domestic ceding insurer, if the assuming
16 insurers' accreditation has been revoked by the commissioner after
17 notice and hearing. An accredited reinsurer is one [which (1)] that (A)
18 files with the commissioner evidence of its submission to this state's
19 jurisdiction, [(2)] (B) submits to this state's authority to examine its
20 books and records, [(3)] (C) is licensed to transact insurance or
21 reinsurance in at least one state, or in the case of a United States branch
22 of an alien assuming insurer is entered through and licensed to
23 transact insurance or reinsurance in at least one state, and [(4)] (D) files
24 annually with the commissioner a copy of its annual statement filed
25 with the insurance department of its state of domicile and a copy of its
26 most recent audited financial statement, and either [(A)] (i) maintains a
27 surplus as regards policyholders in an amount which is not less than
28 twenty million dollars and whose accreditation has not been denied by
29 the commissioner within ninety days of its submission, or [(B)] (ii)
30 maintains a surplus as regards policyholders in an amount less than
31 twenty million dollars and whose accreditation has been approved by
32 the commissioner.

33 (2) Each accredited reinsurer doing business in this state shall,
34 annually, on or before the first day of March, submit to the
35 commissioner, by electronically filing with the National Association of
36 Insurance Commissioners, a true and complete report, signed and
37 sworn to by its president or a vice president, and secretary or an
38 assistant secretary, of its financial condition on the thirty-first day of
39 December next preceding, prepared in accordance with the National
40 Association of Insurance Commissioners annual statement instructions
41 handbook and following those accounting procedures and practices
42 prescribed by the National Association of Insurance Commissioners
43 accounting practices and procedures manual, subject to any deviations
44 in form and detail as may be prescribed by the commissioner. An
45 electronically filed report in accordance with section 38a-53a that is
46 timely submitted to the National Association of Insurance
47 Commissioners is deemed to have been submitted to the commissioner
48 in accordance with this subdivision.

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

61 (e) (1) Credit shall be allowed when the reinsurance is ceded to an
62 assuming insurer which maintains a trust fund in a qualified United
63 States financial institution, as defined in subsection (b) of section 38a-
64 87, for the payment of the valid claims of its United States
65 policyholders and ceding insurers, their assigns and successors in
66 interest. The assuming insurer shall report annually to the
67 commissioner information substantially the same as that required to be
68 reported on in the National Association of Insurance Commissioners'
69 Annual Statement form by licensed insurers to enable the
70 commissioner to determine the sufficiency of the trust fund. In the case
71 of a single assuming insurer, the trust shall consist of a trusteed
72 account representing the assuming insurer's liabilities attributable to
73 business written in the United States and, in addition, the assuming
74 insurer shall maintain a trusteed surplus of not less than twenty
75 million dollars. In the case of a group including incorporated and
76 individual unincorporated underwriters, the trust shall consist of a
77 trusteed account representing the group's liabilities attributable to
78 business written in the United States and, in addition, the group shall
79 maintain a trusteed surplus of which one hundred million dollars shall
80 be held jointly for the benefit of United States ceding insurers of any
81 member of the group; the incorporated members of the group shall not
82 be engaged in any business other than underwriting as a member of

83 the group and shall be subject to the same level of solvency regulation
84 and control by the group's domiciliary regulator as are the
85 unincorporated members; and the group shall make available to the
86 commissioner an annual certification of the solvency of each
87 underwriter by the group's domiciliary regulator and its independent
88 public accountants.

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

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

106 (4) Each assuming insurance company shall, on or before the first
107 day of March, submit to the commissioner, and electronically to the
108 National Association of Insurance Commissioners, a true and complete
109 report, signed and sworn to by its president or a vice president, and
110 secretary or an assistant secretary, of its financial condition of the trust
111 on the thirty-first day of December next preceding, prepared in
112 accordance with the National Association of Insurance Commissioners
113 annual statement instructions handbook and following those
114 accounting procedures and practices prescribed by the National
115 Association of Insurance Commissioners accounting practices and

116 procedures manual, subject to any deviations in form and detail as
117 may be prescribed by the commissioner. An electronically filed report
118 in accordance with section 38a-53a that is timely submitted to the
119 National Association of Insurance Commissioners does not exempt an
120 assuming insurance company from timely filing a true and complete
121 paper copy with the commissioner.

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

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

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

147 (B) An insurer licensed in this state to transact surety insurance or

148 reinsurance, but not financial guaranty insurance pursuant to sections
149 38a-92 to 38a-92n, inclusive, or accredited as a reinsurer in this state as
150 provided in subdivision (1) of subsection (c) of section 38a-85, as
151 amended by this act, if the insurer or reinsurer meets all of the
152 following criteria: (i) Has and maintains combined capital and surplus
153 of at least fifty million dollars; (ii) establishes and maintains the
154 reserves required in section 38a-92c, except that if the reinsurance
155 agreement is nonproportional, the contribution to the contingency
156 reserve shall be equal to fifty per cent of the quarterly written
157 insurance premium; (iii) complies with the provisions of subsection (b)
158 of section 38a-92i, except that its maximum aggregate assumed total
159 net liability shall be one-half that permitted for a financial guaranty
160 insurance corporation. For the purpose of determining compliance, the
161 reinsurer, unless at the time of cession and thereafter it is rated in one
162 of the two top generic rating classifications by a securities rating
163 agency acceptable to the commissioner, shall be limited to using ten
164 per cent of its capital and surplus in making this calculation; (iv)
165 complies with the provisions of section 38a-92j; and (v) assumes,
166 together with all other reinsurers subject to this subparagraph, less
167 than fifty per cent of the ceding insurer's total liability after deducting
168 any reinsurance ceded to any insurers pursuant to subparagraph (A) of
169 this subdivision.

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

173 (a) (1) Each domestic insurance company or health care center shall,
174 annually, on or before the first day of March, submit to the
175 commissioner, and electronically to the National Association of
176 Insurance Commissioners, a true and complete report, signed and
177 sworn to by its president or a vice president, and secretary or an
178 assistant secretary, of its financial condition on the thirty-first day of
179 December next preceding, prepared in accordance with the National
180 Association of Insurance Commissioners annual statement instructions
181 handbook and following those accounting procedures and practices

182 prescribed by the National Association of Insurance Commissioners
183 accounting practices and procedures manual, subject to any deviations
184 in form and detail as may be prescribed by the commissioner. An
185 electronically filed report in accordance with section 38a-53a that is
186 timely submitted to the National Association of Insurance
187 Commissioners does not exempt a domestic insurance company or
188 health care center from timely filing a true and complete paper copy
189 with the commissioner.

190 (2) Each accredited reinsurer, as defined in subsection (c) of section
191 38a-85, as amended by this act, and assuming insurance company, as
192 provided in section 38a-85, as amended by this act, shall file an annual
193 report in accordance with the provisions of section 38a-85, as amended
194 by this act.

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

197 (a) [Any] Each risk retention group not domiciled in this state
198 [which] that is doing business in this state shall submit to the
199 Insurance Commissioner: (1) A copy of the group's financial statement
200 submitted to its state of domicile, which shall be certified by an
201 independent public accountant and contain a statement of opinion on
202 loss and loss adjustment expense reserves made by a member of the
203 American Academy of Actuaries or a qualified loss reserve specialist;
204 (2) a copy of each examination of the risk retention group as certified
205 by the commissioner or public official conducting the examination; (3)
206 upon request by the commissioner, a copy of any audit performed
207 with respect to the risk retention group; and (4) such information as
208 may be required to verify that it satisfies the definitional requirements
209 of subdivision (11) of section 38a-250.

210 (b) Each risk retention group doing business in this state shall,
211 annually, on or before the first day of March, submit to the
212 commissioner, by electronically filing with the National Association of
213 Insurance Commissioners, a true and complete report, signed and

214 sworn to by its president or a vice president, and secretary or an
215 assistant secretary, of its financial condition on the thirty-first day of
216 December next preceding, prepared as submitted to its state of
217 domicile.

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

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

229 As used in this title, unless the context otherwise requires or a
230 different meaning is specifically prescribed, "health insurance" policy
231 means insurance providing benefits due to illness or injury, resulting
232 in loss of life, loss of earnings, or expenses incurred, and includes the
233 following types of coverage: (1) Basic hospital expense coverage; (2)
234 basic medical-surgical expense coverage; (3) hospital confinement
235 indemnity coverage; (4) major medical expense coverage; (5) disability
236 income protection coverage; (6) accident only coverage; (7) long term
237 care coverage; (8) specified accident coverage; (9) Medicare
238 supplement coverage; (10) limited benefit health coverage; (11)
239 hospital or medical service plan contract; (12) hospital and medical
240 coverage provided to subscribers of a health care center; (13) specified
241 disease coverage; (14) TriCare supplement coverage.

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

244 The Insurance Commissioner shall provide written or electronic
245 notification to each insurance company, fraternal benefit society,

246 hospital service corporation, medical service corporation, health care
247 center or any other entity that delivers or issues for delivery, in this
248 state, any individual or group health insurance plan (1) of any benefits
249 required to be provided in such plan pursuant to this chapter, or of
250 any modification to such benefits on or after October 1, 2006, at least
251 thirty days prior to the date such benefits or modification becomes
252 effective, and (2) instructing such company, society, corporation,
253 center or other entity to submit to the Insurance Commissioner, prior
254 to the date such benefits or modification becomes effective or upon the
255 renewal date of the plan, any necessary policy forms, in accordance
256 with the provisions of section 38a-481 or 38a-513, as applicable, that
257 reflect such benefits or modification.

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

261 (d) (1) Not later than five business days after receiving a written
262 request from the commissioner, enrollee or any provider acting on
263 behalf of an enrollee with the enrollee's consent, a managed care
264 organization or health insurer whose enrollee is the subject of an
265 appeal shall provide to the commissioner, enrollee or any provider
266 acting on behalf of an enrollee with the enrollee's consent, written
267 verification of whether the enrollee's plan is fully insured, self-funded,
268 or otherwise funded. If the plan is a fully insured plan or a self-insured
269 governmental plan, the managed care organization or health insurer
270 shall send: (A) Written certification to the commissioner or reviewing
271 entity, as determined by the commissioner, that the benefit or service
272 subject to the appeal is a covered benefit or service; (B) a copy of the
273 entire policy or contract between the enrollee and the managed care
274 organization or health insurer, except that with respect to a self-
275 insured governmental plan, (i) the managed care organization or
276 health insurer shall notify the plan sponsor, and (ii) the plan sponsor
277 shall send, or require the managed care organization or health insurer
278 to send, such copy; or (C) written certification that the policy or
279 contract is accessible to the review entity electronically and clear and

280 simple instructions on how to electronically access the policy or
281 contract.

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

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

303 Every individual health insurance policy providing coverage of the
304 type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of
305 section 38a-469, as amended by this act, delivered, issued for delivery,
306 amended or renewed in this state on or after January 1, 2009, shall
307 provide that coverage of a child shall terminate no earlier than the
308 policy anniversary date on or after whichever of the following occurs
309 first, the date on which the child: [marries, or] Marries; ceases to be a
310 resident of the state; becomes covered under a group health plan
311 through the dependent's own employment; or attains the age of
312 twenty-six. [as long as the child is a resident of the state except for full-

313 time attendance at an out-of-state accredited institution of higher
314 education or resides out of state with a custodial parent pursuant to a
315 child custody determination, as defined in section 46b-115a] The
316 residency requirement shall not apply to dependent children under
317 nineteen years of age or full-time students attending an accredited
318 institution of higher education.

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

323 (a) The plan shall be one under which the individuals eligible to be
324 covered include: (1) Each eligible employee; (2) the spouse of each
325 eligible employee, who shall be considered a dependent for the
326 purposes of this section; and (3) unmarried children [residing in the
327 state,] who are under twenty-six years of age.

328 (b) The plan shall provide the option to continue coverage under
329 each of the following circumstances until the individual is eligible for
330 other group insurance, except as provided in subdivisions (3) and (4)
331 of this subsection: (1) Notwithstanding any provision of this section,
332 upon layoff, reduction of hours, leave of absence, or termination of
333 employment, other than as a result of death of the employee or as a
334 result of such employee's "gross misconduct" as that term is used in 29
335 USC 1163(2), continuation of coverage for such employee and such
336 employee's covered dependents for the periods set forth for such event
337 under federal extension requirements established by the federal
338 Consolidated Omnibus Budget Reconciliation Act of 1985, [(P.L. 99-
339 272)] P.L. 99-272, as amended from time to time, [(COBRA),] except
340 that if such reduction of hours, leave of absence or termination of
341 employment results from an employee's eligibility to receive Social
342 Security income, continuation of coverage for such employee and such
343 employee's covered dependents until midnight of the day preceding
344 such person's eligibility for benefits under Title XVIII of the Social
345 Security Act; (2) upon the death of the employee, continuation of

346 coverage for the covered dependents of such employee for the periods
347 set forth for such event under federal extension requirements
348 established by the Consolidated Omnibus Budget Reconciliation Act of
349 1985, [(P.L. 99-272)] P.L. 99-272, as amended from time to time; [,
350 (COBRA);] (3) regardless of the employee's or dependent's eligibility
351 for other group insurance, during an employee's absence due to illness
352 or injury, continuation of coverage for such employee and such
353 employee's covered dependents during continuance of such illness or
354 injury or for up to twelve months from the beginning of such absence;
355 (4) regardless of an individual's eligibility for other group insurance,
356 upon termination of the group plan, coverage for covered individuals
357 who were totally disabled on the date of termination shall be
358 continued without premium payment during the continuance of such
359 disability for a period of twelve calendar months following the
360 calendar month in which the plan was terminated, provided claim is
361 submitted for coverage within one year of the termination of the plan;
362 (5) the coverage of any covered individual shall terminate: (A) As to a
363 child, the plan shall provide the option for said child to continue
364 coverage for the longer of the following periods: (i) At the end of the
365 month following the month in which the child: [~~marries, or~~] Marries;
366 ceases to be a resident of the state; becomes covered under a group
367 health plan through the dependent's own employment; or attains the
368 age of twenty-six. [, provided the child is a resident of the state except
369 for full-time attendance at an out-of-state accredited institution of
370 higher education or resides out of state with a custodial parent
371 pursuant to a child custody determination, as defined in section 46b-
372 115a] The residency requirement shall not apply to dependent children
373 under nineteen years of age or full-time students attending an
374 accredited institution of higher education. If on the date specified for
375 termination of coverage on a child, the child is unmarried and
376 incapable of self-sustaining employment by reason of mental or
377 physical handicap and chiefly dependent upon the employee for
378 support and maintenance, the coverage on such child shall continue
379 while the plan remains in force and the child remains in such
380 condition, provided proof of such handicap is received by the carrier

381 within thirty-one days of the date on which the child's coverage would
382 have terminated in the absence of such incapacity. The carrier may
383 require subsequent proof of the child's continued incapacity and
384 dependency but not more often than once a year thereafter, or (ii) for
385 the periods set forth for such child under federal extension
386 requirements established by the Consolidated Omnibus Budget
387 Reconciliation Act of 1985, [(P.L. 99-272)] P.L. 99-272, as amended from
388 time to time; [, (COBRA);] (B) as to the employee's spouse, at the end of
389 the month following the month in which a divorce, court-ordered
390 annulment or legal separation is obtained, whichever is earlier, except
391 that the plan shall provide the option for said spouse to continue
392 coverage for the periods set forth for such events under federal
393 extension requirements established by the Consolidated Omnibus
394 Budget Reconciliation Act of 1985, [(P.L. 99-272)] P.L. 99-272, as
395 amended from time to time; [, (COBRA);] and (C) as to the employee
396 or dependent who is sixty-five years of age or older, as of midnight of
397 the day preceding such person's eligibility for benefits under Title
398 XVIII of the federal Social Security Act; (6) as to any other event listed
399 as a "qualifying event" in 29 USC 1163, as amended from time to time,
400 continuation of coverage for such periods set forth for such event in 29
401 USC 1162, as amended from time to time, provided such plan may
402 require the individual whose coverage is to be continued to pay up to
403 the percentage of the applicable premium as specified for such event in
404 29 USC 1162, as amended from time to time. Any continuation of
405 coverage required by this section except subdivision (4) or (6) of this
406 subsection may be subject to the requirement, on the part of the
407 individual whose coverage is to be continued, that such individual
408 contribute that portion of the premium the individual would have
409 been required to contribute had the employee remained an active
410 covered employee, except that the individual may be required to pay
411 up to one hundred two per cent of the entire premium at the group
412 rate if coverage is continued in accordance with subdivision (1), (2) or
413 (5) of this subsection. The employer shall not be legally obligated by
414 sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, to pay such
415 premium if not paid timely by the employee.

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

418 (a) Sections 38a-858 to 38a-875, inclusive, shall provide coverage for
419 the policies and contracts specified in subsection (f) of this section: (1)
420 To any person, except for a nonresident certificate holder under a
421 group policy or contract, who is the beneficiary, assignee or payee of
422 the person covered under subdivision (2) of this subsection, regardless
423 of where the person resides, and (2) any person who is the owner of, or
424 certificate holder under, such policy or contract and in each case who
425 (A) is a resident, or (B) is not a resident, provided (i) the insurer that
426 issued such policy or contract is domiciled in this state, (ii) the state in
427 which the person resides has an association similar to the association
428 created by this section and sections 38a-837, 38a-838, 38a-845, 38a-853,
429 38a-862, 38a-863, 38a-865 and 38a-866, and (iii) the person is not
430 eligible for coverage by an association in any other state because the
431 insurer was not licensed in the state at the time specified in the state's
432 guaranty association law.

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

443 (c) For structured settlement annuities specified in subsection (f) of
444 this section, subdivisions (1) and (2) of subsection (a) of this section
445 shall not apply, and except as provided in subsections (d) and (e) of
446 this section, sections 38a-858 to 38a-875, inclusive, shall apply to a
447 person who is a payee under a structured settlement annuity, or to a
448 beneficiary of a payee if the payee is deceased, if the payee: (1) Is a

449 resident, regardless of where the contract owner resides, or (2) is not a
450 resident, provided: (A) (i) The contract owner of the structured
451 settlement annuity is a resident, or (ii) the contract owner of the
452 structured settlement annuity is not a resident, but the insurer that
453 issued the structured settlement annuity is domiciled in this state, and
454 the state in which the contract owner resides has an association similar
455 to the association created by sections 38a-858 to 38a-875, inclusive; and
456 (B) neither the payee, beneficiary or contract owner is eligible for
457 coverage by the association of the state in which the payee, beneficiary
458 or contract owner resides.

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

465 (e) Sections 38a-858 to 38a-875, inclusive, shall provide coverage to a
466 person who is a resident and, in special circumstances, to a
467 nonresident. In order to avoid duplicate coverage, if a person who
468 would otherwise receive coverage under sections 38a-858 to 38a-875,
469 inclusive, is provided coverage under the laws of any other state, the
470 person shall not be provided coverage under sections 38a-858 to 38a-
471 875, inclusive. In determining the application of the provisions of this
472 subsection in situations where a person could be covered by the
473 association of more than one state, whether as an owner, payee,
474 beneficiary or assignee, sections 38a-858 to 38a-875, inclusive, shall be
475 construed in conjunction with the laws of other states to result in
476 coverage by only one association.

477 (f) (1) Sections 38a-858 to 38a-875, inclusive shall provide coverage
478 to the persons specified in subsections (a) to (d), inclusive, of this
479 section for direct, nongroup life, health or annuity policies or contracts
480 and supplemental contracts to such policies or contracts, for certificates
481 under direct group policies and contracts, and for unallocated annuity

482 contracts issued by member insurers, except as limited by said
483 sections. Annuity contracts and certificates under group annuity
484 contracts include, but are not limited to, guaranteed investment
485 contracts, deposit administration contracts, unallocated funding
486 agreements, allocated funding agreements, structured settlement
487 annuities, annuities issued to or in connection with government
488 lotteries and any immediate or deferred annuity contracts. (2) Said
489 sections 38a-858 to 38a-875, inclusive, shall not provide coverage for:
490 (A) Any portion of a policy or contract not guaranteed by the insurer,
491 or under which the risk is borne by the policy or contract holder; (B)
492 any policy or contract of reinsurance, unless assumption certificates
493 have been issued; (C) any portion of a policy or contract to the extent
494 that the rate of interest on which it is based or the interest rate,
495 crediting rate or similar factor determined by use of an index or other
496 external reference stated in the policy or contract employed in
497 calculating returns or changes in value (i) averaged over the period of
498 four years prior to the date on which the member insurer becomes an
499 impaired or insolvent insurer under sections 38a-858 to 38a-875,
500 inclusive, exceeds the rate of interest determined by subtracting two
501 percentage points from Moody's corporate bond yield average
502 averaged for that same four-year period or for such lesser period if the
503 policy or contract was issued less than four years before the member
504 insurer becomes an impaired or insolvent insurer under sections 38a-
505 858 to 38a-875, inclusive, whichever is earlier; and (ii) on and after the
506 date on which the member insurer becomes an impaired or insolvent
507 insurer under sections 38a-858 to 38a-875, inclusive, whichever is
508 earlier, exceeds the rate of interest determined by subtracting three
509 percentage points from Moody's corporate bond yield average as most
510 recently available; (D) any plan or program of an employer, association
511 or similar entity to provide life, health or annuity benefits to its
512 employees or members to the extent that such plan or program is self-
513 funded or uninsured, including, but not limited to, benefits payable by
514 an employer, association or similar entity under (i) a multiple
515 employer welfare arrangement as defined in Section 514 of the federal
516 Employee Retirement Income Security Act of 1974, as amended from

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

552 trustee, which in each case is not an affiliate of the member insurer;
553 and [(M)] (N) a portion of a policy or contract to the extent it provides
554 for interest or other changes in value to be determined by the use of an
555 index or other external reference stated in the policy or contract, but
556 which have not been credited to the policy or contract, or as to which
557 the policy or contract owner's rights are subject to forfeiture, as of the
558 date the member insurer becomes an impaired or insolvent insurer
559 under sections 38a-858 to 38a-875, inclusive, whichever is earlier. If a
560 policy's or contract's interest or changes in value are credited less
561 frequently than annually, then for purposes of determining the values
562 that have been credited and are not subject to forfeiture under this
563 subparagraph, the interest or change in value determined by using the
564 procedures defined in the policy or contract shall be credited as if the
565 contractual date of crediting interest or changing values was the date
566 of impairment or insolvency, whichever is earlier, and shall not be
567 subject to forfeiture.

568 (g) The benefits for which the association may become liable shall in
569 no event exceed the lesser of: (1) The contractual obligations for which
570 the insurer is liable or would have been liable if it were not an
571 impaired insurer, or (2) (A) with respect to any one life, regardless of
572 the number of policies or contracts: (i) Five hundred thousand dollars
573 in life insurance death benefits, but no more than five hundred
574 thousand dollars in net cash surrender and net cash withdrawal values
575 for life insurance; (ii) five hundred thousand dollars in health
576 insurance benefits, including, but not limited to, any net cash
577 surrender and net cash withdrawal values; (iii) five hundred thousand
578 dollars in the present value of annuity benefits, including, but not
579 limited to, net cash surrender and net cash withdrawal values; (B) with
580 respect to each individual participating in a governmental retirement
581 plan established under Section 401, 403(b) or 457 of the United States
582 Internal Revenue Code of 1986, or any subsequent internal revenue
583 code of the United States, as amended from time to time, covered by
584 an unallocated annuity contract or the beneficiaries of each such
585 individual if deceased, in the aggregate, five hundred thousand dollars

586 in present value annuity benefits, including, but not limited to, net
587 cash surrender and net cash withdrawal values; (C) with respect to
588 each payee of a structured settlement annuity, or beneficiary or
589 beneficiaries of the payee if deceased, five hundred thousand dollars in
590 present value annuity benefits, in the aggregate, including, but not
591 limited to, net cash surrender and net cash withdrawal values, if any,
592 provided in no event shall the association be liable to expend (i) more
593 than the five hundred thousand dollars in the aggregate with respect
594 to any one individual under subparagraphs (A), (B) and (C) of this
595 subdivision, and (ii) with respect to one owner of multiple nongroup
596 policies of life insurance, whether the policy owner is an individual,
597 firm, corporation or other person, and whether the persons insured are
598 officers, managers, employees or other persons, more than five million
599 dollars in benefits, regardless of the number of policies and contracts
600 held by the owner; (D) with respect to either (i) one contract owner
601 provided coverage under subparagraph (B) of subdivision (2) of
602 subsection (b) of this section, or (ii) one plan sponsor whose plans own
603 directly or in trust one or more unallocated annuity contracts not
604 included in subdivision (2) of subsection (f) of this section, five million
605 dollars in benefits regardless of the number of contracts with respect to
606 the contract owner or plan sponsor, except that in the case where one
607 or more unallocated annuity contracts are covered contracts under
608 sections 38a-858 to 38a-875, inclusive, and are owned by a trust or
609 other entity for the benefit of two or more plan sponsors, coverage
610 shall be afforded by the association if the largest interest in the trust or
611 entity owning the contract or contracts is held by a plan sponsor whose
612 principal place of business is in this state and in no event shall the
613 association be obligated to cover more than five million dollars in
614 benefits with respect to all such unallocated contracts.

615 (h) The limits set forth in subsection (g) of this section are limits on
616 the benefits for which the association is obligated before taking into
617 account either the association's subrogation and assignment rights or
618 the extent to which those benefits could be provided out of the assets
619 of the impaired or insolvent insurer that are attributable to covered

620 policies. The costs of the association's obligations under sections 38a-
621 858 to 38a-875, inclusive, may be met by the use of assets attributable
622 to covered policies or reimbursed to the association pursuant to the
623 association's subrogation and assignment rights.

624 (i) In performing its obligation to provide coverage under section
625 38a-865, the association shall not be required to guarantee, assume,
626 reinsure or perform, or cause to be guaranteed, assumed, reinsured or
627 performed, the contractual obligations of the insolvent or impaired
628 insurer under a covered policy or contract that does not materially
629 affect the economic value or economic benefit of the covered policy or
630 contract.

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

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

642 "THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE
643 COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR
644 LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER
645 ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO
646 COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT
647 CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR
648 MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE
649 COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY
650 AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE
651 EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS ARE AS

652 FOLLOWS: (INSURER TO SPECIFY SUCH AMOUNTS)."

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

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

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

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

680 "THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE
681 COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR
682 LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER
683 ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO

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

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

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

702 The Insurance Commissioner shall adopt regulations, in accordance
703 with chapter 54, to establish (1) standards for the sale or exchange of
704 annuities, as defined in section 38a-1, [of the general statutes,] to
705 [senior] consumers, and (2) procedures for making recommendations
706 to [senior] consumers regarding the sale or exchange of an annuity.
707 [For purposes of said regulations, "senior consumer" means an
708 individual sixty-five years of age or older, except that in the event of a
709 joint purchase by more than one person, the purchaser shall be
710 considered to be a senior consumer if any of the purchasers is sixty-
711 five years of age or older.]

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

715 (n) The requirements of subsections (h) and (i) of this section shall

716 not apply to a consortium of federally qualified health centers funded
 717 by the state, providing services only to recipients of programs
 718 administered by the Department of Social Services. The Commissioner
 719 of Social Services shall adopt regulations, in accordance with chapter
 720 54, to establish criteria to certify any such federally qualified health
 721 center, including, but not limited to, minimum reserve fund
 722 requirements.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2008</i>	38a-85
Sec. 2	<i>October 1, 2008</i>	38a-92m(a)(2)(B)
Sec. 3	<i>October 1, 2008</i>	38a-53(a)
Sec. 4	<i>October 1, 2008</i>	38a-253
Sec. 5	<i>October 1, 2008</i>	38a-469
Sec. 6	<i>October 1, 2008</i>	38a-477a
Sec. 7	<i>October 1, 2008</i>	38a-478n(d)
Sec. 8	<i>January 1, 2009</i>	38a-497
Sec. 9	<i>January 1, 2009</i>	38a-554
Sec. 10	<i>October 1, 2008</i>	38a-860
Sec. 11	<i>October 1, 2008</i>	38a-482b
Sec. 12	<i>October 1, 2008</i>	38a-513d
Sec. 13	<i>from passage</i>	38a-432a
Sec. 14	<i>from passage</i>	38a-479aa

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either chamber thereof for any purpose:

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill would not result in a fiscal impact to the Department of Insurance (DOI). It requires, among other provisions, (1) that DOI adopt regulations related to selling annuities to all consumers, (2) reinsurers and risk retention groups to file financial statements electronically, and (3) allows DOI to notify health insurance entities of certain new laws electronically. These requirements can be achieved within existing agency resources.

House "A" (LCO 3982) exempts a consortium of federally qualified health centers that provide services only to the Department of Social Services (DSS) from certain minimum reserve requirements. This amends an existing statute to conform it to the agency's operational interpretation of it. This would not result in a fiscal impact to DSS or change the underlying fiscal impact of the bill.

The Out Years

None.

OLR Bill Analysis**sHB 5158 (as amended by House "A")******AN ACT MAKING CHANGES TO THE INSURANCE STATUTES.*****SUMMARY:**

This bill makes substantive and technical changes to the insurance statutes. It:

1. revises the private health insurance coverage requirements for children;
2. redefines "limited coverage" for purposes of determining which health insurance policies must disclose that they do not provide comprehensive benefits;
3. exempts state-funded federally qualified health centers (FQHCs), which are preferred provider networks (PPNs), that provide services only to recipients of programs the Department of Social Services (DSS) administers from the PPN law's net worth and reserve requirements and requires the DSS commissioner to adopt regulations to establish criteria to certify these FQHCs;
4. deletes the 60-day, and leaves a five-business-day, deadline for managed care organizations (MCOs) and health insurers to provide appeal-related information before a presumption of coverage applies during an appeal review;
5. specifies that the Connecticut Life and Health Insurance Guaranty Association does not protect stop-loss and excess-loss insurance policies covering life, health, or annuity benefits;

6. subjects TriCare supplement coverage to state health insurance laws and regulations;
7. requires the insurance commissioner to adopt regulations establishing standards for selling annuities to all consumers, instead of senior consumers only;
8. requires reinsurers and risk retention groups to file financial statements electronically; and
9. allows the commissioner to notify health insurance entities of certain new laws electronically, as an alternative to in writing.

*House Amendment "A" excludes certain FQHCs from the net worth and financial reserve requirements of the PPN law, requires the DSS commissioner to adopt regulations that establish certification criteria for certain FQHCs, and revises the "limited coverage" definition to refer to fixed-dollar benefits of less than \$20,000 on any core services. The definition in the underlying bill referenced fixed-dollar benefits of less than \$20,000 on core services.

EFFECTIVE DATE: October 1, 2008, except for the dependent children provisions, which are effective January 1, 2009, and the FQHC and commissioner's rule-making authority provisions, which are effective upon passage.

§§ 8 & 9 — HEALTH INSURANCE FOR CHILDREN

The bill revises the criteria for determining when a child loses coverage under a private health insurance policy that the legislature enacted in 2007 and made effective January 1, 2009.

Individual Policy

The 2007 acts (PA 07-185 and PA 07-2, JSS) require that a child's health insurance coverage under an individual policy continue at least until the policy's anniversary date on or after the date the child marries or turns age 26, whichever occurs first, as long the child is a Connecticut resident, unless he or she is living out-of-state (1) as a full-

time student at an accredited school of higher education or (2) with a custodial parent pursuant to a child custody determination.

The bill instead requires a child's coverage under an individual policy to continue at least until the policy anniversary date on or after the date the child:

1. marries;
2. ends his or her Connecticut residency, unless he or she is (a) under age 19 or (b) a full-time student at an accredited school of higher education;
3. becomes covered under a group health plan through his or her employment; or
4. turns age 26.

Group Plan and Continued Coverage

The 2007 acts require group comprehensive health care plans to (1) extend coverage eligibility to unmarried children who are under age 26 and Connecticut residents and (2) offer continuation coverage to the end of the month following the month in which the child marries or turns age 26, as long as the child is a Connecticut resident, unless he or she is living out-of-state (a) as a full-time student at an accredited school of higher education or (b) with a custodial parent pursuant to a child custody determination.

The bill instead requires group comprehensive care plans to (1) extend coverage eligibility to unmarried children under age 26 (thus eliminating the residency requirement and related exception) and (2) to offer continuation coverage to the end of the month in which the child meets the criteria for losing coverage under an individual policy.

§§ 11 & 12 — LIMITED COVERAGE DEFINITION

The bill defines "limited coverage" as a health insurance policy covering basic hospital expenses, basic medical-surgical expenses,

major medical expenses, or hospital or medical services, including an HMO contract, that includes (1) an annual maximum benefit of less than \$100,000 or (2) fixed-dollar benefits of less than \$20,000 on any core services, instead of a per-service or -condition benefit limit of less than \$20,000. It defines “core services” as medical, surgical, and hospital services, including inpatient and outpatient physician, laboratory, and imaging services.

By law, each individual and group health insurance policy, contract, or certificate issued in Connecticut that provides limited coverage, and any related advertising, marketing, and enrollment material, must include a conspicuous statement that the plan does not provide comprehensive medical coverage. It also prohibits insurers and other entities from replacing an employer-sponsored comprehensive health insurance plan with a policy that provides limited coverage.

§ 14 — NET WORTH AND RESERVE EXEMPTION

The bill specifies that a state-funded FQHC consortium that provides services only to recipients of DSS-administered programs are exempt from the provisions of the law governing PPNs that require the networks to (1) have a minimum net worth and (2) maintain minimum reserves to pay outstanding amounts due to providers (see BACKGROUND).

The bill requires the DSS commissioner to adopt regulations to establish criteria, including minimum reserve requirements, to certify these FQHCs.

DSS currently contracts with an FQHC consortium to deliver services to State Administered General Assistance recipients. By law, DSS may contract with an FQHC consortium to deliver services to Charter Oak Health Plan recipients, and the consortium must obtain certification from the DSS commissioner to participate in the plan in accordance with criteria, including minimum reserve requirements, that the commissioner establishes.

§ 7 — APPEAL-RELATED INFORMATION

Under current law, an insurer's or MCO's failure to provide appeal-related information or notify a plan sponsor of a plan document request within five business days from the request or the 60-day appeal period, whichever is later, creates certain presumptions and may require the MCO or insurer to pay appeal-related costs. The bill eliminates the 60-day timeframe for this purpose, and instead allows the presumptions and payment responsibility to apply after the five business days pass.

By law, when an insurer or MCO does not reply within the stated time period, it (1) creates a presumption that the benefit or service being appealed is a covered benefit for purposes of the Insurance Department or its designated review entity to accept the appeal for full review and (2) entitles the insurance commissioner to require the insurer or MCO to reimburse the department for appeal-related expenses. The presumption does not create or authorize benefits or services exceeding those in the enrollee's policy or contract.

§ 10 — LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

The Connecticut Life and Health Insurance Guaranty Association pays certain life, health, and annuity claims when a life and health insurance company becomes financially impaired or insolvent. By law, it does not provide protection against impaired HMOs, fraternal benefit societies, unauthorized or unlicensed insurers, self-funded plans, and stop-loss group insurance plans.

The bill changes "stop-loss group insurance plans" to stop-loss or excess-loss insurance policies providing (1) indemnification or (2) payment to a policy or contract owner, plan, or other person obligated to pay life, health, or annuity benefits. (Stop-loss and excess-loss policies are insurance policies that cover losses over a stated amount.)

§ 5 — TRICARE SUPPLEMENT COVERAGE

Existing law defines "health insurance" for purposes of the

insurance statutes. This bill adds TriCare supplement coverage to the list of coverage types that a health insurance policy may include. (TriCare is a federal health benefit program for military personnel and their dependents.)

By law, unless an insurance statute specifically indicates or the context requires something different, a “health insurance” policy (1) is insurance providing benefits for illness or injury resulting in death, loss of earnings, or expenses incurred and (2) includes coverage for basic hospital or medical-surgical expense, hospital confinement indemnity, major medical expense, disability income, accident only, long-term care, specified accident, Medicare supplement, limited benefit, hospital or medical service plan, hospital and medical coverage an HMO provides, or specified disease.

§ 13 — REGULATIONS FOR ANNUITY SALES

The bill requires the insurance commissioner to adopt regulations establishing standards and procedures for annuity transactions (sales or exchanges) involving all consumers, instead of senior consumers (those age 65 or older) only.

§§ 1- 4 — FINANCIAL REPORTING

The bill requires assuming and accredited reinsurers and risk retention groups (RRGs) doing business in Connecticut to file complete, accurate financial reports by March 1 annually for the previous calendar year with the insurance commissioner by electronically filing them with the National Association of Insurance Commissioners (NAIC). The company president or vice-president and secretary or assistant secretary must sign and swear to the reports.

A reinsurer must prepare its reports following NAIC instructions and accounting practices and procedures, unless the commissioner requires or approves any deviations. An RRG must prepare its reports as its home state requires. Assuming reinsurers must also give the commissioner a paper copy of the report.

By law, an annual statement filed electronically with the NAIC must include any additional information the insurance commissioner prescribes, the signed jurat (notary) page, and actuarial certification. Financial analysis ratios and examination synopses concerning companies that NAIC provides the Insurance Department are confidential and not to subject to public disclosure.

A reinsurer is an insurance company for other insurance companies. An assuming reinsurer accepts all or part of the other insurer's risks in accordance with a reinsurance contract. An accredited reinsurer is not licensed in Connecticut, but must meet certain specified financial requirements.

An RRG is a type of captive insurance company that federal law permits. It can form as an in-state or out-of-state company. Those set up in other states can do business in Connecticut if they register with the Insurance Department.

§ 6 — INSURANCE DEPARTMENT NOTICE

By law, the insurance commissioner must notify insurers and other entities providing individual or group health insurance plans of any benefits the law requires them to provide, or any modifications in those benefits, in writing at least 30 days before the benefit or modification takes effect. The bill permits the commissioner to send the notice electronically.

BACKGROUND

Health Insurance Coverage for Children

Until the changes in the 2007 acts take effect, a child's coverage under an individual policy is prohibited from ending before the policy anniversary date on or after the date the child (1) marries; (2) is no longer dependent on the policyholder; or (3) turns age 19 or, if a full-time student at an accredited school of higher education, 23, whichever occurs first.

Group comprehensive plans must extend eligibility to each eligible

employee's dependent, unmarried children who are under age 19, or, for full-time students at accredited schools of higher education, 23.

The law also requires group comprehensive care plans to offer a child the option to continue coverage until the end of the month following the month in which the child (1) marries; (2) ceases to be dependent on the employee; or (3) turns age 19 or, if a full-time student at an accredited school of higher education, 23, whichever occurs first.

PPN Requirements

PPNs, which are subject to Insurance Department regulation, (1) pay claims for health care services rendered; (2) accept financial risk; and (3) establish, operate, or maintain arrangements or contracts with providers. By law, each PPN must maintain a minimum net worth of either (1) the greater of \$250,000 or 8% of annual expenditures or (2) an amount the insurance commissioner prescribes. In addition, they must maintain or arrange for a letter of credit, bond, surety, reinsurance, reserve, or other financial security that the commissioner approves for the exclusive use of paying any outstanding amounts owed participating providers in the event of insolvency or nonpayment. At a minimum, this must be the greater of (1) an amount sufficient to pay providers for two months, (2) the actual outstanding amount owed providers, or (3) an amount the commissioner determines. This amount can be credited against the minimum net worth requirement.

Related Bill

sHB 5617 excludes state-funded FQHCs providing services only to DSS-administered programs from the net worth and financial reserve requirements of the PPN law. It requires the FQHCs to obtain (1) certification from the DSS commissioner in accordance with criteria he establishes and (2) a license from the insurance commissioner if required under law.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 17 Nay 0 (03/13/2008)