



House of Representatives

File No. 967

General Assembly

January Session, 2009

(Reprint of File No. 312)

Substitute House Bill No. 6527
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
May 15, 2009

AN ACT CONCERNING MINOR CHANGES TO THE INSURANCE AND RELATED STATUTES.

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

1 Section 1. Subdivision (15) of subsection (a) of section 38a-25 of the
2 general statutes is repealed and the following is substituted in lieu
3 thereof (*Effective from passage*):

4 (15) (A) Captive insurers, as defined in section 38a-91k, as amended
5 by this act, and (B) captive insurance companies, as defined in section
6 38a-91aa, if a registered agent cannot be found with reasonable
7 diligence at the registered office of a captive insurance company.

8 Sec. 2. Subsection (d) of section 38a-91ff of the general statutes is
9 repealed and the following is substituted in lieu thereof (*Effective from*
10 *passage*):

11 (d) In the case of a captive insurance company:

12 (1) ~~[(A)]~~ Formed as a corporation, before the articles of
13 incorporation are transmitted to the Secretary of the State, the

14 incorporators shall petition the Insurance Commissioner to issue a
15 certificate setting forth the commissioner's finding that the
16 establishment and maintenance of the proposed corporation will
17 promote the general good of the state. In arriving at such a finding the
18 commissioner shall consider:

19 [(i)] (A) The character, reputation, financial standing and purposes
20 of the incorporators;

21 [(ii)] (B) The character, reputation, financial responsibility, insurance
22 experience and business qualifications of the officers and directors;
23 and

24 [(iii)] (C) Such other aspects as the commissioner deems advisable.

25 [(B) The articles of incorporation, such certificate and the
26 organization fee shall be transmitted to the Secretary of the State who
27 shall record both the articles of incorporation and the certificate.]

28 (2) Formed as a reciprocal insurer, the organizers shall petition the
29 commissioner to issue a certificate setting forth the commissioner's
30 finding that the establishment and maintenance of the proposed
31 association will promote the general good of the state. In arriving at
32 such a finding the commissioner shall consider the items set forth in
33 [subparagraph (A) of] subdivision (1) of this subsection.

34 (3) Formed as a limited liability company, before the articles of
35 organization are transmitted to the Secretary of the State, the
36 organizers shall petition the commissioner to issue a certificate setting
37 forth the commissioner's finding that the establishment and
38 maintenance of the proposed company will promote the general good
39 of the state. In arriving at such a finding, the commissioner shall
40 consider the items set forth in [subparagraph (A) of] subdivision (1) of
41 this subsection.

42 (4) The articles of incorporation and certificate set forth in
43 subdivisions (1) to (3), inclusive, of this subsection shall be transmitted

44 to the Secretary of the State along with any fees required by the
45 Secretary of the State, who shall record both the articles of
46 incorporation and the certificate.

47 Sec. 3. Section 38a-465a of the general statutes is repealed and the
48 following is substituted in lieu thereof (*Effective from passage*):

49 (a) Except as otherwise provided in this part, no person shall act as a
50 provider or broker until the person is licensed by the commissioner
51 pursuant to this section.

52 (b) Any applicant for a license as a provider or broker shall submit
53 written application to the commissioner. Such applicants shall provide
54 such information as the commissioner requires. All initial applications
55 shall be accompanied by a filing fee specified in section 38a-11.

56 (c) A life insurance producer, who has been duly licensed as a
57 resident insurance producer with a life line of authority in this state or
58 in said producer's home state for not less than one year and is licensed
59 as a nonresident producer pursuant to section 38a-702g, shall be
60 deemed to meet the licensing requirements of this section and shall be
61 permitted to operate as a broker.

62 (d) Not later than thirty days from the first day of operating as a
63 broker, a life insurance producer shall notify the commissioner that
64 said producer is acting as a broker on a form prescribed by the
65 commissioner, and shall pay a filing fee as specified in section 38a-11.
66 Such notification shall include an acknowledgement by the life
67 insurance producer that said producer shall operate as a broker in
68 accordance with this part.

69 (e) The insurer that issued the policy that is the subject of a life
70 settlement contract shall not be responsible for any act or omission of a
71 broker, provider or purchaser arising out of or in connection with the
72 life settlement transaction, unless the insurer receives compensation
73 for the placement of a life settlement contract from the broker,
74 provider or purchaser in connection with such life settlement contract.

75 (f) A person licensed as an attorney, certified public accountant or
76 financial planner accredited by a nationally recognized accreditation
77 agency, who is retained to represent the owner and whose
78 compensation is not paid directly or indirectly by the provider or
79 purchaser, may negotiate life settlement contracts on behalf of the
80 owner without being required to obtain a license as a broker.

81 (g) Any license issued for a provider or broker shall be in force only
82 until the last day of March in each year, but may be renewed by the
83 commissioner without formality other than proper application. The
84 fees for such licenses shall be assessed annually, as provided in section
85 38a-11. If such provider or broker fails to timely pay the renewal fee,
86 such license shall be automatically revoked if the license fee is not
87 received by the commissioner not later than the fifth day after the
88 commissioner sends, by first class mail, a written notice of nonrenewal
89 to the principal office of the provider or broker, provided such notice
90 shall only be mailed after said last day of March.

91 [(h) The term of a provider license shall be equal to that of a
92 domestic stock life insurance company and the term of a broker license
93 shall be equal to that of an insurance producer license. Licenses
94 requiring periodic renewal shall be renewed on their anniversary date
95 upon payment of the renewal fee, as specified in subsection (b) of this
96 section. Failure to pay the fees on or before the renewal date shall
97 result in expiration of the license.]

98 [(i) (h) Upon the filing of an application and full payment of the
99 license fee, the commissioner shall investigate the applicant and shall
100 issue a license if the commissioner determines that:

101 (1) The applicant, if a provider, has provided a detailed plan of
102 operation;

103 (2) The applicant is competent and trustworthy, and intends to act
104 in good faith pursuant to the license applied for;

105 (3) The applicant has a good business reputation and adequate

106 experience, training or education so as to be qualified in the business
107 for which the license is applied;

108 (4) If the applicant is a corporation, partnership, limited liability
109 company or other legal entity, the applicant is formed or organized
110 pursuant to the laws of this state or is a foreign legal entity authorized
111 to do business in this state, or provides a certificate of good standing
112 from its state of domicile; and

113 (5) The applicant has provided to the commissioner an antifraud
114 plan that meets the requirements of subsection (i) of section 38a-465j
115 and includes:

116 (A) A description of the procedures for detecting and investigating
117 possible fraudulent acts and procedures for resolving material
118 inconsistencies between medical records and insurance applications;

119 (B) A description of the procedures for reporting fraudulent
120 insurance acts to the commissioner;

121 (C) A description of the plan for antifraud education and training of
122 its underwriters and other personnel; and

123 (D) A written description or chart outlining the arrangement of the
124 antifraud personnel responsible for the investigation and reporting of
125 possible fraudulent insurance acts and investigating unresolved
126 material inconsistencies between medical records and insurance
127 applications.

128 [(j)] (i) The applicant shall provide to the commissioner such
129 information as the commissioner may require, on forms approved by
130 the commissioner. The commissioner may, at any time, require the
131 applicant to fully disclose the identity of its stockholders, except
132 stockholders owning less than ten per cent of the shares of an applicant
133 whose shares are publicly traded, partners, officers and employees,
134 and the commissioner may deny any application for a license if the
135 commissioner determines that any partner, officer, employee or

136 stockholder thereof who may materially influence the applicant's
137 conduct fails to meet any of the standards set forth in sections 38a-465
138 to 38a-465q, inclusive.

139 [(k)] (j) A license issued to a corporation, partnership, limited
140 liability company or other legal entity authorizes all of such legal
141 entity's members, officers and designated employees named in the
142 application for such license, and any supplements to the application, to
143 act as a licensee under such license.

144 [(l)] (k) The commissioner shall not issue any license to any
145 nonresident applicant unless a written designation of an agent for
146 service of process is filed and maintained with the commissioner or
147 unless the applicant has filed with the commissioner the applicant's
148 written irrevocable consent that any action against the applicant may
149 be commenced against the applicant by service of process on the
150 commissioner.

151 [(m)] (l) Each licensee shall file with the commissioner on or before
152 the first day of March of each year an annual statement containing
153 such information as the commissioner may prescribe by regulation.

154 [(n)] (m) A provider shall not use any person to perform the
155 functions of a broker, as defined in this part, unless such person holds
156 a current, valid license as a broker and as provided in this section.

157 [(o)] (n) A broker shall not use any person to perform the functions
158 of a provider, as defined in this part, unless such person holds a
159 current, valid license as a provider and as provided in this section.

160 [(p)] (o) A provider or broker shall provide to the commissioner
161 new or revised information about officers, stockholders holding ten
162 per cent or more of the company's stock, partners, directors, members
163 or designated employees not later than thirty days after the change in
164 information.

165 [(q)] (p) An individual licensed as a broker shall complete, on a

166 biennial basis, fifteen hours of training related to life settlements and
167 life settlement transactions, except that a life insurance producer
168 operating as a broker pursuant to this section shall not be subject to the
169 requirements of this subsection. Any person failing to meet the
170 requirements of this subsection shall be subject to the penalties
171 imposed by the commissioner.

172 Sec. 4. Section 38a-465g of the general statutes is repealed and the
173 following is substituted in lieu thereof (*Effective from passage*):

174 (a) Before entering into a life settlement contract with any owner of
175 a policy wherein the insured is terminally ill or chronically ill, a
176 provider shall obtain:

177 (1) If the owner is the insured, a written statement from a licensed
178 attending physician that the owner is of sound mind and under no
179 constraint or undue influence to enter into the settlement contract; and

180 (2) A document in which the insured consents to the release of the
181 insured's medical records to a provider, broker or insurance producer,
182 and, if the policy was issued less than two years from the date of
183 application for a settlement contract, to the insurance company that
184 issued the policy.

185 (b) The insurer shall respond to a request for verification of
186 coverage submitted by a provider, broker or life insurance producer on
187 a form approved by the commissioner not later than thirty calendar
188 days after the date the request was received. The insurer shall
189 complete and issue the verification of coverage or indicate in which
190 respects it is unable to respond. In its response, the insurer shall
191 indicate whether, based on the medical evidence and documents
192 provided, the insurer intends to pursue an investigation regarding the
193 validity of the policy.

194 (c) Prior to or at the time of execution of the settlement contract, the
195 provider shall obtain a witnessed document in which the owner
196 consents to the settlement contract, represents that the owner has a full

197 and complete understanding of the settlement contract, that the owner
198 has a full and complete understanding of the benefits of the policy,
199 acknowledges that the owner is entering into the settlement contract
200 freely and voluntarily and, for persons with a terminal or chronic
201 illness or condition, acknowledges that the insured has a terminal or
202 chronic illness or condition and that the terminal or chronic illness or
203 condition was diagnosed after the life insurance policy was issued.

204 (d) If a broker or life insurance producer performs any of the
205 activities required of the provider under this section, the provider shall
206 be deemed to have fulfilled the requirements of this section.

207 [(e) If a broker performs the verification of coverage activities
208 required of the provider, the provider shall be deemed to have fulfilled
209 the requirements of subsection (a) of section 38a-465f.]

210 [(f)] (e) The insurer shall not unreasonably delay effecting change of
211 ownership or beneficiary with any life settlement contract lawfully
212 entered into in this state or with a resident of this state.

213 [(g)] (f) Not later than twenty days after an owner executes the life
214 settlement contract, the provider shall give written notice to the insurer
215 that issued the policy that the policy has become subject to a life
216 settlement contract. The notice shall be accompanied by [the
217 documents set forth in subsection (c) of section 38a-465h] a copy of the
218 medical records release required under subdivision (2) of subsection
219 (a) of this section and a copy of the insured's application for the life
220 settlement contract.

221 [(h)] (g) All medical information solicited or obtained by any person
222 licensed pursuant to this part shall be subject to applicable provisions
223 of law relating to the confidentiality of medical information.

224 [(i)] (h) Each life settlement contract entered into in this state shall
225 provide that the owner may rescind the contract not later than fifteen
226 days from the date it is executed by all parties thereto. Such rescission
227 exercised by the owner shall be effective only if both notice of

228 rescission is given to the provider and the owner repays all proceeds
229 and any premiums, loans and loan interest paid by the provider within
230 the rescission period. A failure to provide written notice of the right of
231 rescission shall toll the period of such right until thirty days after the
232 written notice of the right of rescission has been given. If the insured
233 dies during the rescission period, the contract shall be deemed to have
234 been rescinded, subject to repayment by the owner or the owner's
235 estate of all proceeds and any premiums, loans and loan interest to the
236 provider.

237 [(j)] (i) Not later than three business days after the date the provider
238 receives the documents from the owner to effect the transfer of the
239 insurance policy, the provider shall pay or transfer the proceeds of the
240 settlement into an escrow or trust account managed by a trustee or
241 escrow agent in a state or federally-chartered financial institution
242 whose deposits are insured by the Federal Deposit Insurance
243 Corporation. Not later than three business days after receiving
244 acknowledgment of the transfer of the insurance policy from the issuer
245 of the policy, said trustee or escrow agent shall pay the settlement
246 proceeds to the owner.

247 [(k)] (j) Failure to tender the life settlement (j) contract proceeds to the
248 owner within the time set forth in section 38a-465f shall render the
249 viatical settlement contract voidable by the owner for lack of
250 consideration until the time such consideration is tendered to, and
251 accepted by, the owner.

252 [(l)] (k) Any fee paid by a provider, party, individual or an owner to
253 a broker in exchange for services provided to the owner pertaining to a
254 life settlement contract shall be computed as a percentage of the offer
255 obtained and not as a percentage of the face value of the policy.
256 Nothing in this section shall be construed to prohibit a broker from
257 reducing such broker's fee below such percentage.

258 [(m)] (l) Each broker shall disclose to the owner anything of value
259 paid or given to such broker in connection with a life settlement

260 contract concerning the owner.

261 [(n)] (m) No person at anytime prior to, or at the time of, the
262 application for or issuance of a policy, or during a two-year period
263 commencing with the date of issuance of the policy, shall enter into a
264 life settlement contract regardless of the date the compensation is to be
265 provided and regardless of the date the assignment, transfer, sale,
266 devise, bequest or surrender of the policy is to occur. This prohibition
267 shall not apply if the owner certifies to the provider that:

268 (1) The policy was issued upon the owner's exercise of conversion
269 rights arising out of a group or individual policy, provided the total of
270 the time covered under the conversion policy plus the time covered
271 under the prior policy is not less than twenty-four months. The time
272 covered under a group policy must be calculated without regard to a
273 change in insurance carriers, provided the coverage has been
274 continuous and under the same group sponsorship; or

275 (2) The owner submits independent evidence to the provider that
276 one or more of the following conditions have been met within said
277 two-year period: (A) The owner or insured is terminally ill or
278 chronically ill; (B) the owner or insured disposes of the owner or
279 insured's ownership interests in a closely held corporation, pursuant to
280 the terms of a buyout or other similar agreement in effect at the time
281 the insurance policy was initially issued; (C) the owner's spouse dies;
282 (D) the owner divorces his or her spouse; (E) the owner retires from
283 full-time employment; (F) the owner becomes physically or mentally
284 disabled and a physician determines that the disability prevents the
285 owner from maintaining full-time employment; or (G) a final order,
286 judgment or decree is entered by a court of competent jurisdiction on
287 the application of a creditor of the owner, adjudicating the owner
288 bankrupt or insolvent, or approving a petition seeking reorganization
289 of the owner or appointing a receiver, trustee or liquidator to all or a
290 substantial part of the owner's assets.

291 [(o)] (n) Copies of the independent evidence required by

292 subdivision (2) of subsection [(n)] (m) of this section shall be submitted
293 to the insurer when the provider submits a request to the insurer for
294 verification of coverage. The copies shall be accompanied by a letter of
295 attestation from the provider that the copies are true and correct copies
296 of the documents received by the provider. Nothing in this section
297 shall prohibit an insurer from exercising its right to contest the validity
298 of any policy.

299 [(p)] (o) If, at the time the provider submits a request to the insurer
300 to effect the transfer of the policy to the provider, the provider submits
301 a copy of independent evidence of subparagraph (A) of subdivision (2)
302 of subsection [(n)] (m) of this section, such copy shall be deemed to
303 establish that the settlement contract satisfies the requirements of this
304 section.

305 Sec. 5. Subsection (b) of section 38a-479rr of the general statutes is
306 repealed and the following is substituted in lieu thereof (*Effective from*
307 *passage*):

308 (b) (1) A current and accurate list of authorized marketers, specified
309 in subparagraph (M) of subdivision (2) of subsection (a) of this section,
310 shall be submitted to the commissioner with each renewal fee, as set
311 forth in subsection (c) of this section.

312 (2) Any change made to the list of authorized marketers, specified in
313 subparagraph (M) of subdivision (2) of subsection (a) of this section,
314 shall be electronically filed with the commissioner. If such change is to
315 add a marketer to a medical discount plan organization's list of
316 authorized marketers, such change shall be electronically filed by such
317 organization prior to the marketer doing business in the state for such
318 organization.

319 (3) The commissioner may adopt regulations, in accordance with
320 chapter 54, to establish the procedure and format of the electronic
321 filing [and acknowledgment] set forth in this subsection.

322 Sec. 6. Section 38a-492j of the general statutes is repealed and the

323 following is substituted in lieu thereof (*Effective January 1, 2010*):

324 Each individual health insurance policy providing coverage of the
325 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
326 469 delivered, issued for delivery, renewed, amended or continued in
327 this state [on or after October 1, 2000,] that provides coverage for
328 ostomy surgery shall include coverage, up to one thousand dollars
329 annually, for medically necessary appliances and supplies relating to
330 an ostomy including, but not limited to, collection devices, irrigation
331 equipment and supplies, skin barriers and skin protectors. As used in
332 this section, "ostomy" includes colostomy, ileostomy and urostomy.
333 Payments under this section shall not be applied to any policy
334 maximums for durable medical equipment. Nothing in this section
335 shall be deemed to decrease policy benefits in excess of the limits in
336 this section.

337 Sec. 7. Section 38a-504 of the general statutes is repealed and the
338 following is substituted in lieu thereof (*Effective January 1, 2010*):

339 (a) Each insurance company, hospital service corporation, medical
340 service corporation, health care center or fraternal benefit society
341 [which] that delivers, [or] issues for delivery, renews, amends or
342 continues in this state individual health insurance policies providing
343 coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and
344 (12) of section 38a-469, shall provide coverage under such policies for
345 the surgical removal of tumors and treatment of leukemia, including
346 outpatient chemotherapy, reconstructive surgery, cost of any
347 nondental prosthesis including any maxillo-facial prosthesis used to
348 replace anatomic structures lost during treatment for head and neck
349 tumors or additional appliances essential for the support of such
350 prosthesis, outpatient chemotherapy following surgical procedure in
351 connection with the treatment of tumors, and a wig if prescribed by a
352 licensed oncologist for a patient who suffers hair loss as a result of
353 chemotherapy. Such benefits shall be subject to the same terms and
354 conditions applicable to all other benefits under such policies.

355 (b) Except as provided in subsection (c) of this section, the coverage
356 required by subsection (a) of this section shall provide at least a yearly
357 benefit of five hundred dollars for the surgical removal of tumors, five
358 hundred dollars for reconstructive surgery, five hundred dollars for
359 outpatient chemotherapy, three hundred fifty dollars for a wig and
360 three hundred dollars for a nondental prosthesis, except that for
361 purposes of the surgical removal of breasts due to tumors the yearly
362 benefit for prosthesis shall be at least three hundred dollars for each
363 breast removed.

364 (c) The coverage required by subsection (a) of this section shall
365 provide benefits for the reasonable costs of reconstructive surgery on
366 each breast on which a mastectomy has been performed, and
367 reconstructive surgery on a nondiseased breast to produce a
368 symmetrical appearance. Such benefits shall be subject to the same
369 terms and conditions applicable to all other benefits under such
370 policies. For the purposes of this subsection, reconstructive surgery
371 includes, but is not limited to, augmentation mammoplasty, reduction
372 mammoplasty and mastopexy.

373 Sec. 8. Subsection (a) of section 38a-517a of the general statutes is
374 repealed and the following is substituted in lieu thereof (*Effective*
375 *January 1, 2010*):

376 (a) Each group health insurance policy providing coverage of the
377 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
378 469 delivered, issued for delivery, renewed, amended or continued in
379 this state [on or after January 1, 2000,] shall provide coverage for
380 general anesthesia, nursing and related hospital services provided in
381 conjunction with in-patient, outpatient or one-day dental services if the
382 following conditions are met:

383 (1) The anesthesia, nursing and related hospital services are deemed
384 medically necessary by the treating dentist or oral surgeon and the
385 patient's primary care physician in accordance with the health
386 insurance policy's requirements for prior authorization of services; and

387 (2) The patient is either (A) determined by a licensed dentist, in
388 conjunction with a licensed physician who specializes in primary care,
389 to have a dental condition of significant dental complexity that it
390 requires certain dental procedures to be performed in a hospital, or (B)
391 a person who has a developmental disability, as determined by a
392 licensed physician who specializes in primary care, that places the
393 person at serious risk.

394 Sec. 9. Section 38a-518j of the general statutes is repealed and the
395 following is substituted in lieu thereof (*Effective January 1, 2010*):

396 Each group health insurance policy providing coverage of the type
397 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
398 delivered, issued for delivery, renewed, amended or continued in this
399 state [on or after October 1, 2000,] that provides coverage for ostomy
400 surgery shall include coverage, up to one thousand dollars annually,
401 for medically necessary appliances and supplies relating to an ostomy
402 including, but not limited to, collection devices, irrigation equipment
403 and supplies, skin barriers and skin protectors. As used in this section,
404 "ostomy" includes colostomy, ileostomy and urostomy. Payments
405 under this section shall not be applied to any policy maximums for
406 durable medical equipment. Nothing in this section shall be deemed to
407 decrease policy benefits in excess of the limits in this section.

408 Sec. 10. Section 38a-542 of the general statutes is repealed and the
409 following is substituted in lieu thereof (*Effective January 1, 2010*):

410 (a) Each insurance company, hospital service corporation, medical
411 service corporation, health care center or fraternal benefit society
412 [which] that delivers, [or] issues for delivery, renews, amends or
413 continues in this state group health insurance policies providing
414 coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)
415 of section 38a-469 shall provide coverage under such policies for
416 treatment of leukemia, including outpatient chemotherapy,
417 reconstructive surgery, cost of any nondental prosthesis, including any
418 maxillo-facial prosthesis used to replace anatomic structures lost

419 during treatment for head and neck tumors or additional appliances
420 essential for the support of such prosthesis, outpatient chemotherapy
421 following surgical procedures in connection with the treatment of
422 tumors, a wig if prescribed by a licensed oncologist for a patient who
423 suffers hair loss as a result of chemotherapy, and costs of removal of
424 any breast implant which was implanted on or before July 1, 1994,
425 without regard to the purpose of such implantation, which removal is
426 determined to be medically necessary. Such benefits shall be subject to
427 the same terms and conditions applicable to all other benefits under
428 such policies.

429 (b) Except as provided in subsection (c) of this section, the coverage
430 required by subsection (a) of this section shall provide at least a yearly
431 benefit of one thousand dollars for the costs of removal of any breast
432 implant, five hundred dollars for the surgical removal of tumors, five
433 hundred dollars for reconstructive surgery, five hundred dollars for
434 outpatient chemotherapy, three hundred fifty dollars for a wig and
435 three hundred dollars for a nondental prosthesis, except that for
436 purposes of the surgical removal of breasts due to tumors the yearly
437 benefit for prosthesis shall be at least three hundred dollars for each
438 breast removed.

439 (c) The coverage required by subsection (a) of this section shall
440 provide benefits for the reasonable costs of reconstructive surgery on
441 each breast on which a mastectomy has been performed, and
442 reconstructive surgery on a nondiseased breast to produce a
443 symmetrical appearance. Such benefits shall be subject to the same
444 terms and conditions applicable to all other benefits under such
445 policies. For the purposes of this subsection, reconstructive surgery
446 includes, but is not limited to, augmentation mammoplasty, reduction
447 mammoplasty and mastopexy.

448 Sec. 11. Section 14-64 of the general statutes is repealed and the
449 following is substituted in lieu thereof (*Effective from passage*):

450 The commissioner may suspend or revoke the license or licenses of

451 any licensee or impose a civil penalty of not more than one thousand
452 dollars for each violation on any licensee or both, when, after notice
453 and hearing, the commissioner finds that the licensee (1) has violated
454 any provision of any statute or regulation of any state or any federal
455 statute or regulation pertaining to its business as a licensee or has
456 failed to comply with the terms of a final decision and order of any
457 state department or federal agency concerning any such provision; or
458 (2) has failed to maintain such records of transactions concerning the
459 purchase, sale or repair of motor vehicles or major component parts, as
460 required by such regulations as shall be adopted by the commissioner,
461 for a period of two years after such purchase, sale or repairs, provided
462 the records shall include the vehicle identification number and the
463 name and address of the person from whom each vehicle or part was
464 purchased and to whom each vehicle or part was sold, if a sale
465 occurred; or (3) has failed to allow inspection of such records by the
466 commissioner or the commissioner's representative during normal
467 business hours, provided written notice stating the purpose of the
468 inspection is furnished to the licensee, or has failed to allow inspection
469 of such records by any representative of the Division of State Police
470 within the Department of Public Safety or any organized local police
471 department, which inspection may include examination of the
472 premises to determine the accuracy of such records; or (4) has made a
473 false statement as to the condition, prior ownership or prior use of any
474 motor vehicle sold, exchanged, transferred, offered for sale or repaired
475 if the licensee knew or should have known that such statement was
476 false; or (5) is not qualified to conduct the licensed business, applying
477 the standards of section 14-51 and the applicable regulations; or (6) has
478 violated any provision of sections 42-221 to 42-226, inclusive; or (7) has
479 failed to fully execute or provide the buyer with (A) an order as
480 described in section 14-62, (B) the properly assigned certificate of title,
481 or (C) a temporary transfer or new issue of registration; or (8) has
482 failed to deliver a motor vehicle free and clear of all liens, unless
483 written notification is given to the buyer stating such motor vehicle
484 shall be purchased subject to a lien; or (9) has violated any provision of
485 sections 14-65f to 14-65j, inclusive, 14-65l and 14-65m; or (10) has used

486 registration number plates issued by the commissioner, in violation of
487 the provisions and standards set forth in sections 14-59 and 14-60 and
488 the applicable regulations; or (11) has failed to secure or to account for
489 or surrender to the commissioner on demand official registration
490 plates or any other official materials in its custody. In addition to, or in
491 lieu of, the imposition of any other penalties authorized by this section,
492 the commissioner may order any such licensee to make restitution to
493 any aggrieved customer.

494 Sec. 12. Section 14-65e of the general statutes is repealed and the
495 following is substituted in lieu thereof (*Effective from passage*):

496 For the purposes of sections 14-65f to 14-65j, inclusive, 14-65l and
497 14-65m, "motor vehicle repair shop" or "repair shop" means a new car
498 dealer, a used car dealer, a repairer, or a limited repairer, as defined in
499 section 14-51, or their agents or employees.

500 Sec. 13. Subsection (a) of section 14-65g of the general statutes is
501 repealed and the following is substituted in lieu thereof (*Effective from*
502 *passage*):

503 (a) A customer may waive his right to the estimate of the costs of
504 parts and labor required by section 14-65f, only in writing in
505 accordance with this section. Such a waiver shall include an
506 authorization to perform reasonable and necessary repairs to remedy
507 the problems complained of, at a cost not to exceed a fixed dollar
508 amount. The waiver shall be signed by the customer and the customer
509 shall be given a fully completed copy of the waiver at the time it is
510 signed. No repair shop shall use waivers to evade its duties under
511 sections 14-65e to 14-65j, inclusive, 14-65l and 14-65m, as amended by
512 this act.

513 Sec. 14. Section 14-65k of the general statutes is repealed and the
514 following is substituted in lieu thereof (*Effective from passage*):

515 (a) The Commissioner of Motor Vehicles may conduct
516 investigations and hold hearings on any matter under the provisions of

517 sections 14-51 to 14-65j, inclusive, 14-65l and 14-65m. The
518 commissioner may issue subpoenas, administer oaths, compel
519 testimony and order the production of books, records and documents.
520 If any person refuses to appear, to testify or to produce any book,
521 record, paper or document when so ordered, upon application of the
522 commissioner, a judge of the Superior Court may make such order as
523 may be appropriate to aid in the enforcement of this section.

524 (b) The Attorney General, at the request of the commissioner, is
525 authorized to apply in the name of the state of Connecticut to the
526 Superior Court for an order temporarily or permanently restraining
527 and enjoining any person from violating any provision of sections 14-
528 51 to 14-65j, inclusive, 14-65l and 14-65m.

529 Sec. 15. Section 29-152n of the general statutes is repealed and the
530 following is substituted in lieu thereof (*Effective from passage*):

531 Any person who violates any provision of sections 29-152e to
532 29-152m, inclusive, [and 38a-660a] shall be guilty of a class D felony.

533 Sec. 16. Section 38a-91k of the general statutes is repealed and the
534 following is substituted in lieu thereof (*Effective from passage*):

535 Each captive insurer that is domiciled in another state and offers,
536 renews or continues insurance in this state shall provide the
537 information described in subdivisions (1) to (3), inclusive, of
538 subsection (a) of section 38a-253 to the Insurance Commissioner in the
539 same manner required for risk retention groups. If a captive insurer
540 does not maintain information in the form prescribed in section 38a-
541 253, the captive insurer may submit the information to the Insurance
542 Commissioner on such form as the commissioner prescribes. As used
543 in this section and section 38a-25, as amended by this act, "captive
544 insurer" means an insurance company owned by another organization
545 whose primary purpose is to insure risks of a parent organization or
546 affiliated persons, as defined in section 38a-1, or in the case of groups
547 and associations, an insurance organization owned by the insureds
548 whose primary purpose is to insure risks of member organizations and

549 group members and their affiliates.

550 Sec. 17. Section 38a-491a of the general statutes is repealed and the
551 following is substituted in lieu thereof (*Effective January 1, 2010*):

552 (a) Each individual health insurance policy providing coverage of
553 the type specified in subdivisions (1), (2), (4), (11) and (12) of section
554 38a-469 delivered, issued for delivery, renewed, amended or continued
555 in this state [on or after January 1, 2000,] shall provide coverage for
556 general anesthesia, nursing and related hospital services provided in
557 conjunction with in-patient, outpatient or one-day dental services if the
558 following conditions are met:

559 (1) The anesthesia, nursing and related hospital services are deemed
560 medically necessary by the treating dentist or oral surgeon and the
561 patient's primary care physician in accordance with the health
562 insurance policy's requirements for prior authorization of services; and

563 (2) The patient is either (A) determined by a licensed dentist, in
564 conjunction with a licensed physician who specializes in primary care,
565 to have a dental condition of significant dental complexity that it
566 requires certain dental procedures to be performed in a hospital, or (B)
567 a person who has a developmental disability, as determined by a
568 licensed physician who specializes in primary care, that places the
569 person at serious risk.

570 (b) The expense of such anesthesia, nursing and related hospital
571 services shall be deemed a medical expense under such health
572 insurance policy and shall not be subject to any limits on dental
573 benefits under such policy.

574 Sec. 18. Section 38a-556 of the general statutes is repealed and the
575 following is substituted in lieu thereof (*Effective from passage*):

576 There is hereby created a nonprofit legal entity to be known as the
577 Health Reinsurance Association. All insurers, health care centers and
578 self-insurers doing business in the state, as a condition to their

579 authority to transact the applicable kinds of health insurance defined
580 in section 38a-551, shall be members of the association. The association
581 shall perform its functions under a plan of operation established and
582 approved under subdivision (a) of this section, and shall exercise its
583 powers through a board of directors established under this section.

584 (a) (1) The board of directors of the association shall be made up of
585 nine individuals selected by participating members, subject to
586 approval by the commissioner, two of whom shall be appointed by the
587 commissioner on or before July 1, 1993, to represent health care
588 centers. To select the initial board of directors, and to initially organize
589 the association, the commissioner shall give notice to all members of
590 the time and place of the organizational meeting. In determining
591 voting rights at the organizational meeting each member shall be
592 entitled to vote in person or proxy. The vote shall be a weighted vote
593 based upon the net health insurance premium derived from this state
594 in the previous calendar year. If the board of directors is not selected
595 within sixty days after notice of the organizational meeting, the
596 commissioner may appoint the initial board. In approving or selecting
597 members of the board, the commissioner may consider, among other
598 things, whether all members are fairly represented. Members of the
599 board may be reimbursed from the moneys of the association for
600 expenses incurred by them as members, but shall not otherwise be
601 compensated by the association for their services. (2) The board shall
602 submit to the commissioner a plan of operation for the association
603 necessary or suitable to assure the fair, reasonable and equitable
604 administration of the association. The plan of operation shall become
605 effective upon approval in writing by the commissioner consistent
606 with the date on which the coverage under sections 38a-505, 38a-546
607 and 38a-551 to 38a-559, inclusive, must be made available. The
608 commissioner shall, after notice and hearing, approve the plan of
609 operation provided such plan is determined to be suitable to assure the
610 fair, reasonable and equitable administration of the association, and
611 provides for the sharing of association gains or losses on an equitable
612 proportionate basis. If the board fails to submit a suitable plan of

613 operation within one hundred eighty days after its appointment, or if
614 at any time thereafter the board fails to submit suitable amendments to
615 the plan, the commissioner shall, after notice and hearing, adopt and
616 promulgate such reasonable rules as are necessary or advisable to
617 effectuate the provisions of this section. Such rules shall continue in
618 force until modified by the commissioner or superseded by a plan
619 submitted by the board and approved by the commissioner. The plan
620 of operation shall, in addition to requirements enumerated in sections
621 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive: (A) Establish
622 procedures for the handling and accounting of assets and moneys of
623 the association; (B) establish regular times and places for meetings of
624 the board of directors; (C) establish procedures for records to be kept
625 of all financial transactions, and for the annual fiscal reporting to the
626 commissioner; (D) establish procedures whereby selections for the
627 board of directors shall be made and submitted to the commissioner;
628 (E) establish procedures to amend, subject to the approval of the
629 commissioner, the plan of operations; (F) establish procedures for the
630 selection of an [administering carrier] administrator and set forth the
631 powers and duties of the [administering carrier] administrator; (G)
632 contain additional provisions necessary or proper for the execution of
633 the powers and duties of the association; (H) establish procedures for
634 the advertisement on behalf of all participating carriers of the general
635 availability of the comprehensive coverage under sections 38a-505,
636 38a-546 and 38a-551 to 38a-559, inclusive; (I) contain additional
637 provisions necessary for the association to qualify as an acceptable
638 alternative mechanism in accordance with Section 2744 of the Public
639 Health Service Act, as set forth in the Health Insurance Portability and
640 Accountability Act of 1996, [(P.L. 104-191)] P.L. 104-191; and (J) contain
641 additional provisions necessary for the association to qualify as
642 acceptable coverage in accordance with the Pension Benefit Guaranty
643 Corporation and Trade Adjustment Assistance programs of the Trade
644 Act of 2002, [(P.L. 107-210)] P.L. 107-210. The commissioner may adopt
645 regulations, in accordance with the provisions of chapter 54, to
646 establish criteria for the association to qualify as an acceptable
647 alternative mechanism.

648 (b) The association shall have the general powers and authority
649 granted under the laws of this state to carriers to transact the kinds of
650 insurance defined under section 38a-551, and in addition thereto, the
651 specific authority to: (1) Enter into contracts necessary or proper to
652 carry out the provisions and purposes of sections 38a-505, 38a-546 and
653 38a-551 to 38a-559, inclusive; (2) sue or be sued, including taking any
654 legal actions necessary or proper for recovery of any assessments for,
655 on behalf of, or against participating members; (3) take such legal
656 action as necessary to avoid the payment of improper claims against
657 the association or the coverage provided by or through the association;
658 (4) establish, with respect to health insurance provided by or on behalf
659 of the association, appropriate rates, scales of rates, rate classifications
660 and rating adjustments, such rates not to be unreasonable in relation to
661 the coverage provided and the operational expenses of the association;
662 (5) administer any type of reinsurance program, for or on behalf of
663 participating members; (6) pool risks among participating members;
664 (7) issue policies of insurance on an indemnity or provision of service
665 basis providing the coverage required by sections 38a-505, 38a-546 and
666 38a-551 to 38a-559, inclusive, in its own name or on behalf of
667 participating members; (8) administer separate pools, separate
668 accounts or other plans as deemed appropriate for separate members
669 or groups of members; (9) operate and administer any combination of
670 plans, pools, reinsurance arrangements or other mechanisms as
671 deemed appropriate to best accomplish the fair and equitable
672 operation of the association; (10) set limits on the amounts of
673 reinsurance [which] that may be ceded to the association by its
674 members; (11) appoint from among participating members appropriate
675 legal, actuarial and other committees as necessary to provide technical
676 assistance in the operation of the association, policy and other contract
677 design, and any other function within the authority of the association;
678 and (12) apply for and accept grants, gifts and bequests of funds from
679 other states, federal and interstate agencies and independent
680 authorities, private firms, individuals and foundations for the purpose
681 of carrying out its responsibilities. Any such funds received shall be
682 deposited in the General Fund and shall be credited to a separate

683 nonlapsing account within the General Fund for the Health
684 Reinsurance Association and may be used by the Health Reinsurance
685 Association in the performance of its duties.

686 (c) Every member shall participate in the association in accordance
687 with the provisions of this subdivision. (1) A participating member
688 shall determine the particular risks it elects to have written by or
689 through the association. A member shall designate which of the
690 following classes of risks it shall underwrite in the state, from which
691 classes of risk it may elect to reinsure selected risks: (A) Individual,
692 excluding group conversion; and (B) individual, including group
693 conversion. (2) No member shall be permitted to select out individual
694 lives from an employer group to be insured by or through the
695 association. Members electing to administer risks [which] that are
696 insured by or through the association shall comply with the benefit
697 determination guidelines and the accounting procedures established
698 by the association. A risk insured by or through the association cannot
699 be withdrawn by the participating member except in accordance with
700 the rules established by the association. (3) Rates for coverage issued
701 by or through the association shall not be excessive, inadequate or
702 unfairly discriminatory. Separate scales of premium rates based on age
703 shall apply, but rates shall not be adjusted for area variations in
704 provider costs. Premium rates shall take into consideration the
705 substantial extra morbidity and administrative expenses for
706 association risks, reimbursement or reasonable expenses incurred for
707 the writing of association risks and the level of rates charged by
708 insurers for groups of ten lives, provided incurred losses [which] that
709 result from provision of coverage in accordance with section 38a-537
710 shall not be considered. In no event shall the rate for a given
711 classification or group be less than one hundred twenty-five per cent
712 or more than one hundred fifty per cent of the average rate charged for
713 that classification with similar characteristics under a policy covering
714 ten lives. All rates shall be promulgated by the association through an
715 actuarial committee consisting of five persons who are members of the
716 American Academy of Actuaries, shall be filed with the commissioner

717 and may be disapproved within sixty days from the filing thereof if
718 excessive, inadequate or unfairly discriminatory.

719 (d) (1) Following the close of each fiscal year, the [administering
720 carrier] administrator shall determine the net premiums, reinsurance
721 premiums less administrative expense allowance, the expense of
722 administration pertaining to the reinsurance operations of the
723 association and the incurred losses for the year. Any net loss shall be
724 assessed to all participating members in proportion to their respective
725 shares of the total health insurance premiums earned in this state
726 during the calendar year, or with paid losses in the year, coinciding
727 with or ending during the fiscal year of the association or on any other
728 equitable basis as may be provided in the plan of operations. For self-
729 insured members of the association, health insurance premiums
730 earned shall be established by dividing the amount of paid health
731 losses for the applicable period by eighty-five per cent. Net gains, if
732 any, shall be held at interest to offset future losses or allocated to
733 reduce future premiums. (2) Any net loss to the association
734 represented by the excess of its actual expenses of administering
735 policies issued by the association over the applicable expense
736 allowance shall be separately assessed to those participating members
737 who do not elect to administer their plans. All assessments shall be on
738 an equitable formula established by the board. (3) The association shall
739 conduct periodic audits to assure the general accuracy of the financial
740 data submitted to the association and the association shall have an
741 annual audit of its operations by an independent certified public
742 accountant. The annual audit shall be filed with the commissioner for
743 his review and the association shall be subject to the provisions of
744 section 38a-14. (4) For the fiscal year ending December 31, 1993, and
745 the first quarter of the fiscal year ending December 31, 1994, the
746 [administering carrier] administrator shall not include health care
747 centers in assessing any net losses to participating members.

748 (e) All policy forms issued by or through the association shall
749 conform in substance to prototype forms developed by the association,
750 shall in all other respects conform to the requirements of sections 38a-

751 505, 38a-546 and 38a-551 to 38a-559, inclusive, and shall be approved
752 by the commissioner. The commissioner may disapprove any such
753 form if it contains a provision or provisions which are unfair or
754 deceptive or which encourage misrepresentation of the policy.

755 (f) Unless otherwise permitted by the plan of operation, the
756 association shall not issue, reissue or continue in force comprehensive
757 health care plan coverage with respect to any person who is already
758 covered under an individual or group comprehensive health care plan,
759 or who is sixty-five years of age or older and eligible for Medicare or
760 who is not a resident of this state. Coverage provided to a HIPAA or
761 health care tax credit eligible individual may be terminated to the
762 extent permitted by HIPAA or the Trade Act of 2002, respectively.

763 (g) Benefits payable under a comprehensive health care plan
764 insured by or reinsured through the association shall be paid net of all
765 other health insurance benefits paid or payable through any other
766 source, and net of all health insurance coverages provided by or
767 pursuant to any other state or federal law including Title XVIII of the
768 Social Security Act, Medicare, but excluding Medicaid.

769 (h) There shall be no liability on the part of and no cause of action of
770 any nature shall arise against any carrier or its agents or its employees,
771 the Health Reinsurance Association or its agents or its employees or
772 the residual market mechanism established under the provisions of
773 section 38a-557 or its agents or its employees, or the commissioner or
774 his representatives for any action taken by them in the performance of
775 their duties under sections 38a-505, 38a-546 and 38a-551 to 38a-559,
776 inclusive. This provision shall not apply to the obligations of a carrier,
777 a self-insurer, the Health Reinsurance Association or the residual
778 market mechanism for payment of benefits provided under a
779 comprehensive health care plan.

780 Sec. 19. Section 38a-569 of the general statutes is repealed and the
781 following is substituted in lieu thereof (*Effective from passage*):

782 (a) (1) There is established a nonprofit entity to be known as the

783 "Connecticut Small Employer Health Reinsurance Pool". All insurers
784 issuing health insurance in this state and insurance arrangements
785 providing health plan benefits in this state on and after July 1, 1990,
786 shall be members of the pool.

787 (2) On or before July 15, 1990, the commissioner shall give notice to
788 all insurers and insurance arrangements of the time and place for the
789 initial organizational meeting, which shall take place by September 1,
790 1990. The members shall select the initial board, subject to approval by
791 the commissioner. The board shall consist of at least five and not more
792 than nine representatives of members. There shall be no more than two
793 members of the board representing any one insurer or insurance
794 arrangement. In determining voting rights at the organizational
795 meeting, each member shall be entitled to vote in person or by proxy.
796 The vote shall be weighted based upon net health insurance premium
797 derived from this state in the previous calendar year. To the extent
798 possible, at least one-third of the members of the board shall be
799 domestic insurance companies and at least two-thirds of the members
800 of the board shall be small employer carriers. At least one member of
801 the board shall be a health care center and at least one member shall be
802 a small employer carrier with less than one hundred million dollars in
803 net small employer health insurance premium in this state. The
804 Insurance Commissioner shall be an ex-officio member of the board.
805 The net premium amount shall be adjusted by the board periodically
806 for health care cost inflation. In approving selection of the board, the
807 commissioner shall assure that all members are fairly represented. The
808 membership of all boards subsequent to the initial board shall, to the
809 extent possible, reflect the same distribution of representation as is
810 described in this subdivision.

811 (3) If the initial board is not elected at the organizational meeting,
812 the commissioner shall appoint the initial board within fifteen days of
813 the organizational meeting.

814 (4) Within ninety days after the appointment of such initial board,
815 the board shall submit to the commissioner a plan of operation and

816 thereafter any amendments thereto necessary or suitable to assure the
817 fair, reasonable and equitable administration of the pool. The
818 commissioner shall, after notice and hearing, approve the plan of
819 operation provided he determines it to be suitable to assure the fair,
820 reasonable and equitable administration of the pool, and provides for
821 the sharing of pool gains or losses on an equitable proportionate basis
822 in accordance with the provisions of subsection (d) of this section. The
823 plan of operation shall become effective upon approval in writing by
824 the commissioner consistent with the date on which the coverage
825 under this section shall be made available. If the board fails to submit a
826 suitable plan of operation within one hundred eighty days after its
827 appointment, or at any time thereafter fails to submit suitable
828 amendments to the plan of operation, the commissioner shall, after
829 notice and hearing, adopt and promulgate a plan of operation or
830 amendments, as appropriate. The commissioner shall amend any plan
831 adopted by him, as necessary, at the time a plan of operation is
832 submitted by the board and approved by the commissioner.

833 (5) The plan of operation shall establish procedures for: (A)
834 Handling and accounting of assets and moneys of the pool, and for an
835 annual fiscal reporting to the commissioner; (B) filling vacancies on the
836 board, subject to the approval of the commissioner; (C) selecting an
837 [administering insurer] administrator and setting forth the powers and
838 duties of the [administering insurer] administrator; (D) reinsuring risks
839 in accordance with the provisions of this section; (E) collecting
840 assessments from all members to provide for claims reinsured by the
841 pool and for administrative expenses incurred or estimated to be
842 incurred during the period for which the assessment is made and (F)
843 any additional matters at the discretion of the board.

844 (6) The pool shall have the general powers and authority granted
845 under the laws of Connecticut to insurance companies licensed to
846 transact health insurance and, in addition thereto, the specific
847 authority to: (A) Enter into contracts as are necessary or proper to
848 carry out the provisions and purposes of this section, including the
849 authority, with the approval of the commissioner, to enter into

850 contracts with programs of other states for the joint performance of
851 common functions, or with persons or other organizations for the
852 performance of administrative functions; (B) sue or be sued, including
853 taking any legal actions necessary or proper for recovery of any
854 assessments for, on behalf of, or against members; (C) take such legal
855 action as necessary to avoid the payment of improper claims against
856 the pool; (D) define the array of health coverage products for which
857 reinsurance will be provided, and to issue reinsurance policies, in
858 accordance with the requirements of this section; (E) establish rules,
859 conditions and procedures pertaining to the reinsurance of members'
860 risks by the pool; (F) establish appropriate rates, rate schedules, rate
861 adjustments, rate classifications and any other actuarial functions
862 appropriate to the operation of the pool; (G) assess members in
863 accordance with the provisions of subsection (e) of this section, and to
864 make advance interim assessments as may be reasonable and
865 necessary for organizational and interim operating expenses. Any such
866 interim assessments shall be credited as offsets against any regular
867 assessments due following the close of the fiscal year; (H) appoint from
868 among members appropriate legal, actuarial and other committees as
869 necessary to provide technical assistance in the operation of the pool,
870 policy and other contract design, and any other function within the
871 authority of the pool; and (I) borrow money to effect the purposes of
872 the pool. Any notes or other evidence of indebtedness of the pool not
873 in default shall be legal investments for insurers and may be carried as
874 admitted assets.

875 (b) Any member may reinsure with the pool coverage of an eligible
876 employee of a small employer, or any dependent of such an employee,
877 except that no member may reinsure with the pool coverage of an
878 eligible employee of a small employer, or any dependent of such an
879 employee, whose premium rates are not subject to section 38a-567
880 pursuant to subdivision (22) of section 38a-567. Any reinsurance
881 placed with the pool from the date of the establishment of the pool
882 regarding the coverage of an eligible employee of a small employer, or
883 any dependent of such an employee shall be provided as follows:

884 (1) (A) With respect to a special health care plan or a small employer
885 health care plan, the pool shall reinsure the level of coverage provided;
886 (B) with respect to other plans, the pool shall reinsure the level of
887 coverage provided up to, but not exceeding, the level of coverage
888 provided in a small employer health care plan or the actuarial
889 equivalent thereof as defined and authorized by the board; and (C) in
890 either case, no reinsurance may be provided in any calendar year for a
891 reinsured employee or dependent until five thousand dollars in benefit
892 payments have been made for services provided during that calendar
893 year for that reinsured employee or dependent, which payments
894 would have been reimbursed through said reinsurance in the absence
895 of the annual five-thousand-dollar deductible. The amount of the
896 deductible shall be periodically reviewed by the board and may be
897 adjusted for appropriate factors as determined by the board;

898 (2) With respect to eligible employees, and their dependents,
899 coverage may be reinsured: (A) Within such period of time after the
900 commencement of their coverage under the plan as may be authorized
901 by the board, or (B) commencing January 1, 1992, on the first plan
902 anniversary after the employer's coverage has been in effect with the
903 small employer carrier for a period of three years, and every third plan
904 anniversary thereafter, provided, commencing May 1, 1994,
905 reinsurance pursuant to this subparagraph shall only be permitted
906 with respect to eligible employees and their dependents of a small
907 employer which has no more than two eligible employees as of the
908 applicable anniversary;

909 (3) Reinsurance coverage may be terminated for each reinsured
910 employee or dependent on any plan anniversary;

911 (4) Reinsurance of newborn dependents shall be allowed only if the
912 mother of any such dependent is reinsured as of the date of birth of
913 such child, and all newborn dependents of reinsured persons shall be
914 automatically reinsured as of their date of birth; and

915 (5) Notwithstanding the provisions of subparagraph (A) of

916 subdivision (2) of this subsection: (A) Coverage for eligible employees
917 and their dependents provided under a group policy covering two or
918 more small employers shall not be eligible for reinsurance when such
919 coverage is discontinued and replaced by a group policy of another
920 carrier covering two or more small employers, unless coverage for
921 such eligible employees or dependents was reinsured by the prior
922 carrier; and (B) at the time coverage is assumed for such group by a
923 succeeding carrier, such carrier shall notify the pool of its intention to
924 provide coverage for such group and shall identify the employees and
925 dependents whose coverage will continue to be reinsured. The time
926 limitations for providing such notice shall be established by the pool.

927 (c) Except as provided in subsection (d) of this section, premium
928 rates charged for reinsurance by the pool shall be established at the
929 following percentages of the rate established by the pool for that
930 classification or group with similar characteristics and coverage:

931 (1) One hundred fifty per cent, with respect to all of the eligible
932 employees, and their dependents, of a small employer, all of whose
933 coverage is reinsured in accordance with subdivision (2) of subsection
934 (b) of this section; and

935 (2) Five hundred per cent, with respect to an eligible employee or
936 dependent who is individually reinsured in accordance with
937 subdivision (2) of subsection (b) of this section and is not reinsured
938 with all eligible employees of an employer and their dependents.

939 (d) Premium rates charged for reinsurance by the pool to a health
940 care center which is approved by the Secretary of Health and Human
941 Services as a health maintenance organization pursuant to 42 USC 300
942 et seq., and as such is subject to requirements that limit the amount of
943 risk that may be ceded to the pool, may be modified by the board, if
944 appropriate, to reflect the portion of risk that may be ceded to the pool.

945 (e) (1) Following the close of each fiscal year, the [administering
946 insurer] administrator shall determine the net premiums, the pool
947 expenses of administration and the incurred losses for the year, taking

948 into account investment income and other appropriate gains and
949 losses. For purposes of this section, health insurance premiums earned
950 by insurance arrangements shall be established by adding paid health
951 losses and administrative expenses of the insurance arrangement.
952 Health insurance premiums and benefits paid by a member that are
953 less than an amount determined by the board to justify the cost of
954 collection shall not be considered for purposes of determining
955 assessments. For the purposes of this subsection, "net premiums"
956 means health insurance premiums, less administrative expense
957 allowances.

958 (2) Any net loss for the year shall be recouped by assessments of
959 members. (A) Assessments shall first be apportioned by the board
960 among all members in proportion to their respective shares of the total
961 health insurance premiums earned in this state from health insurance
962 plans and insurance arrangements covering small employers during
963 the calendar year coinciding with or ending during the fiscal year of
964 the pool, or on any other equitable basis reflecting coverage of small
965 employers as may be provided in the plan of operations. An
966 assessment shall be made pursuant to this subparagraph against a
967 health care center, which is approved by the Secretary of Health and
968 Human Services as a health maintenance organization pursuant to 42
969 USC 300e et seq., as amended from time to time, subject to an
970 assessment adjustment formula adopted by the board and approved
971 by the commissioner for such health care centers, which recognizes the
972 restrictions imposed on such health care centers by federal law. Such
973 adjustment formula shall be adopted by the board and approved by
974 the commissioner prior to the first anniversary of the pool's operation.
975 (B) If such net loss is not recouped before assessments totaling five per
976 cent of such premiums from plans and arrangements covering small
977 employers have been collected, additional assessments shall be
978 apportioned by the board among all members in proportion to their
979 respective shares of the total health insurance premiums earned in this
980 state from other individual and group plans and arrangements,
981 exclusive of any individual Medicare supplement policies as defined in

982 section 38a-495 during such calendar year. (C) Notwithstanding the
983 provisions of this subdivision, the assessments to any one member
984 under subparagraph (A) or (B) of this subdivision shall not exceed
985 forty per cent of the total assessment under each subparagraph for the
986 first fiscal year of the pool's operation and fifty per cent of the total
987 assessment under each subparagraph for the second fiscal year. Any
988 amounts abated pursuant to this subparagraph shall be assessed
989 against the other members in a manner consistent with the basis for
990 assessments set forth in this subdivision.

991 (3) If assessments exceed actual losses and administrative expenses
992 of the pool, the excess shall be held at interest and used by the board to
993 offset future losses or to reduce pool premiums. As used in this
994 subsection, "future losses" includes reserves for incurred but not
995 reported claims.

996 (4) Each member's proportion of participation in the pool shall be
997 determined annually by the board based on annual statements and
998 other reports deemed necessary by the board and filed by the member
999 with it. Insurance arrangements shall report to the board claims
1000 payments made and administrative expenses incurred in this state on
1001 an annual basis on a form prescribed by the commissioner.

1002 (5) Provision shall be made in the plan of operation for the
1003 imposition of an interest penalty for late payment of assessments.

1004 (6) The board may defer, in whole or in part, the assessment of a
1005 health care center if, in the opinion of the board: (A) Payment of the
1006 assessment would endanger the ability of the health care center to
1007 fulfill its contractual obligations, or (B) in accordance with standards
1008 included in the plan of operation, the health care center has written,
1009 and reinsured in their entirety, a disproportionate number of special
1010 health care plans. In the event an assessment against a health care
1011 center is deferred in whole or in part, the amount by which such
1012 assessment is deferred may be assessed against the other members in a
1013 manner consistent with the basis for assessments set forth in this

1014 subsection. The health care center receiving such deferment shall
 1015 remain liable to the pool for the amount deferred. The board may
 1016 attach appropriate conditions to any such deferment.

1017 (f) (1) Neither the participation in the pool as members, the
 1018 establishment of rates, forms or procedures nor any other joint or
 1019 collective action required by this section shall be the basis of any legal
 1020 action, criminal or civil liability or penalty against the pool or any of its
 1021 members.

1022 (2) Any person or member made a party to any action, suit [,] or
 1023 proceeding because the person or member served on the board or on a
 1024 committee or was an officer or employee of the pool shall be held
 1025 harmless and be indemnified by the program against all liability and
 1026 costs, including the amounts of judgments, settlements, fines or
 1027 penalties, and expenses and reasonable attorney's fees incurred in
 1028 connection with the action, suit or proceeding. The indemnification
 1029 shall not be provided on any matter in which the person or member is
 1030 finally adjudged in the action, suit or proceeding to have committed a
 1031 breach of duty involving gross negligence, dishonesty, wilful
 1032 misfeasance or reckless disregard of the responsibilities of office. Costs
 1033 and expenses of the indemnification shall be prorated and paid for by
 1034 all members. The Insurance Commissioner may retain actuarial
 1035 consultants necessary to carry out [his] said commissioner's
 1036 responsibilities pursuant to sections 38a-564 to 38a-572, inclusive, and
 1037 such expenses shall be paid by the pool established in this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	38a-25(a)(15)
Sec. 2	<i>from passage</i>	38a-91ff(d)
Sec. 3	<i>from passage</i>	38a-465a
Sec. 4	<i>from passage</i>	38a-465g
Sec. 5	<i>from passage</i>	38a-479rr(b)
Sec. 6	<i>January 1, 2010</i>	38a-492j
Sec. 7	<i>January 1, 2010</i>	38a-504

Sec. 8	<i>January 1, 2010</i>	38a-517a(a)
Sec. 9	<i>January 1, 2010</i>	38a-518j
Sec. 10	<i>January 1, 2010</i>	38a-542
Sec. 11	<i>from passage</i>	14-64
Sec. 12	<i>from passage</i>	14-65e
Sec. 13	<i>from passage</i>	14-65g(a)
Sec. 14	<i>from passage</i>	14-65k
Sec. 15	<i>from passage</i>	29-152n
Sec. 16	<i>from passage</i>	38a-91k
Sec. 17	<i>January 1, 2010</i>	38a-491a
Sec. 18	<i>from passage</i>	38a-556
Sec. 19	<i>from passage</i>	38a-569

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 10 \$	FY 11 \$
Department of Motor Vehicles	TF - Revenue Gain	Potential Minimal	Potential Minimal

Note: TF=Transportation Fund

Municipal Impact: None

Explanation

This bill expands Department of Motor Vehicles (“DMV”) penalties¹ to include violations of motor vehicle shop repair requirements and results in a potential revenue gain to the Transportation Fund. This revenue gain is subject to the number of violators assessed penalties by DMV. Other provisions of the bill do not result in a fiscal impact to the state or municipalities.

House “A” makes a change to the underlying bill and adds language that does not result in a fiscal impact.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to the number of violators assessed penalties by DMV.

¹ Not to exceed \$1,000 per penalty.

OLR Bill Analysis**sHB 6527 (as amended by House "A")******AN ACT CONCERNING MINOR CHANGES TO THE INSURANCE AND RELATED STATUTES.*****SUMMARY:**

This bill makes changes in various insurance and transportation statutes. It:

1. broadens the applicability of several health insurance benefits;
2. specifies penalties for, and expands the Department of Motor Vehicles (DMV) commissioner's authority regarding, violations of the motor vehicle repair shop notice and customer acknowledgement requirements;
3. names the insurance commissioner the agent to receive legal service of process for captive insurance companies (domiciled in Connecticut) if a registered agent cannot be found with reasonable diligence at the registered office;
4. requires all Connecticut-domiciled captive insurers to file a certificate of general good and articles of incorporation, if applicable, with the secretary of the state, instead of only those formed as a corporation;
5. permits the Health Reinsurance Association and the Small Employer Health Reinsurance Pool to select administrators that are not insurers;
6. exempts captive insurers domiciled in Connecticut from offering, renewing, or continuing insurance to submit to the insurance commissioner certain financial statements, risk

retention group examination, and, upon request, risk retention audits; and

7. makes other minor, technical, and conforming changes.

*House Amendment "A" (1) expands the circumstances under which the insurance commissioner acts as the agent to receive legal service of process to include captive insurers domiciled in Connecticut, (2) permits the Health Reinsurance Association and the Small Employer Health Reinsurance Pool to select administrators that are not insurers, (3) requires individual health insurance policies amended on and after January 1, 2010 to cover medically necessary services to certain dental patients, and (4) makes minor changes.

EFFECTIVE DATE: Upon passage, except for the provisions extending the applicability of certain insurance benefit requirements, which are effective January 1, 2010.

§§ 6-10 — HEALTH INSURANCE BENEFITS

The bill broadens the applicability of several health insurance benefits required by law, as described below. Due to federal law (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

Ostomy Appliances and Supplies

The bill requires individual and group health insurance policies amended in Connecticut on and after January 1, 2010 to cover medically necessary ostomy appliances and supplies, including collection devices, irrigation equipment and supplies, and skin barriers and protectors, up to \$1,000 annually. The law already requires policies delivered, issued, renewed, or continued in Connecticut to cover ostomy-related supplies.

Both the bill and current law apply to policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan.

Treatment of Tumors and Leukemia and Related Benefits

The bill requires individual and group health insurance policies renewed, amended, or continued in Connecticut on and after January 1, 2010 to provide certain benefits for the treatment of tumors and leukemia, reconstructive surgery, nondental prosthesis, chemotherapy, and wigs for chemotherapy patients. The law already requires policies issued or delivered in Connecticut to provide these benefits.

Coverage must be subject to the same terms and conditions applicable to other policy benefits. But the policy must provide at least a yearly benefit of \$500 for the surgical removal of tumors; \$500 for reconstructive surgery; \$500 for outpatient chemotherapy; \$350 for a wig; and \$300 for a nondental prosthesis unless the prosthesis is due to the surgical removal of breasts because of tumors, in which case the yearly benefit must be at least \$300 for each breast.

Both the bill and current law apply to (1) individual or group health insurance policies that cover (a) basic hospital expenses; (b) basic medical-surgical expenses; (c) major medical expenses; and (d) hospital or medical services, including coverage under an HMO plan, and (2) individual health insurance policies that provide limited benefit health coverage.

General Anesthesia Relating to Dental Services

The bill requires individual and group health insurance policies amended in Connecticut on and after January 1, 2010 to cover medically necessary general anesthesia, nursing, and related hospital services provided to a patient with a (1) complex dental condition that requires the procedure to be performed in a hospital or (2) developmental disability that places them at serious risk. The law already requires policies delivered, issued, renewed, or continued in Connecticut to cover these services.

Both the bill and current law apply to policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including

coverage under an HMO plan.

§§ 11-14 — MOTOR VEHICLE REPAIR SHOP LAWS

The bill allows the DMV commissioner to impose penalties for violations of the motor vehicle repair shop notice and customer acknowledgement requirements under PA 08-146 (see BACKGROUND). It authorizes the commissioner to suspend or revoke a repair shop's license, fine the shop up to \$1,000 for each violation, or both. In addition to, or in lieu of these penalties, the commissioner may order the licensee to make restitution to an aggrieved customer. By law, the commissioner may impose these penalties for violations of other repair shop laws.

By law, a repair shop customer may waive, in writing, his or her right to a repair estimate. The bill prohibits a repair shop from using waivers to evade its duties under PA 08-146. The law already prohibits waivers to evade duties under other repair shop laws.

The bill authorizes the DMV commissioner to conduct investigations and hearings regarding a repair shop's compliance with PA 08-146. He currently has this authority with respect to other motor vehicle dealer and repairer laws. The bill also allows the attorney general, at the DMV commissioner's request, to seek a restraining order requiring a repair shop to cease violating PA 08-146, a power he has with respect to other repair shop laws.

§§ 1 AND 2 — CAPTIVE INSURERS

The bill names the insurance commissioner the agent to receive legal service of process for captive insurance companies (domiciled in Connecticut), provided a registered agent cannot be found with reasonable diligence at the registered office. Current law makes him agent for captive insurers regardless of domicile.

The bill requires a captive insurance company formed as a reciprocal insurer or LLC to give the secretary of the state, along with any required filing fee, a certificate of general good from the insurance

commissioner and the insurer's articles of incorporation, if applicable. By law, a captive formed as a corporation must already do this.

Captive insurers domiciled in another state offering, renewing, or continuing insurance must submit to the insurance commissioner (1) a copy of the group's financial statement submitted to its state of domicile, certified by an independent public accountant and containing 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; and (3) upon request by the commissioner, a copy of any audit performed with respect to the risk retention group.

§§ 3 AND 4 — LIFE SETTLEMENT STATUTES

The bill resolves a statutory conflict within the license expiration and renewal requirements for life settlement producers and brokers. PA 08-175 both retained the former law's requirements and added new, conflicting ones. The bill retains the former law, specifying that provider and broker licenses expire on March 31 in each year, but may be renewed annually. If a provider or broker fails to pay the renewal fee on time, the commissioner must revoke his or her license, unless he or she pays within five days after the commissioner sends, by first class mail, a written notice of nonrenewal after March 31.

The bill deletes the following provisions: (1) the term of a (a) producer license is equal to that of a domestic stock life insurance company (annual renewal) and (b) broker license is equal to that of an insurance producer (if an individual, renewal is every other year on the person's birth date, and if an entity, February 1 of even-numbered years) and (2) licenses must be renewed on their anniversary dates and that failure to pay the renewal fee by that date results in license expiration.

The bill deletes another confusing and apparently erroneous

provision from PA 08-175. The provision specifies that if a broker verifies the existence of a life insurance policy, then a life settlement provider is deemed to have fulfilled the law's extensive disclosure requirements.

By law, a life settlement provider, within 20 days after a life insurance policy owner executes a life settlement contract, must give the insurer that issued the policy written notice that the policy has become subject to a life settlement contract. The bill requires the provider to send the notice with a copy of the insured's (1) required medical records release form and (2) application for the life settlement contract, instead of with optional disclosure documents.

§ 5 — MEDICAL DISCOUNT PLAN ORGANIZATION

The bill authorizes the insurance commissioner to adopt regulations to establish an electronic filing process, instead of an electronic filing and acknowledgement process, for a medical discount plan organization (MDPO) to follow when updating its filed list of Connecticut marketers operating under a different name from its own.

§ 15 — NOTICE TO COURTS AND POLICE DEPARTMENTS

The bill eliminates the class D felony penalty for the insurance commissioner's failure to provide courts and police departments a list of surety bail bond agents or changes to the list.

BACKGROUND

Repair Shop Notice and Acknowledgment (PA 08-146)

Effective January 1, 2009, the law requires automobile physical damage appraisals or estimates written on an insurer's or a motor vehicle repair shop's behalf to include the following notice in at least 10-point boldface type: NOTICE: YOU HAVE THE RIGHT TO CHOOSE THE LICENSED REPAIR SHOP WHERE THE DAMAGE TO YOUR MOTOR VEHICLE WILL BE REPAIRED (CGS § 14-65l).

The law prohibits a motor vehicle repair shop participating in an insurer's vehicle repair program from repairing a vehicle under that

program unless the claimant (i.e., person whose insured vehicle needs repairs) acknowledges in writing that he or she is aware of the right to have the vehicle repaired at a shop he or she chooses (CGS § 14-65m). The acknowledgement may be (1) included in the repair authorization, which a customer signs before repairs are made, or in a separate document and (2) faxed or e-mailed. The acknowledgement must state: "I am aware of my right to choose the licensed repair shop where the damage to the motor vehicle will be repaired."

By law, no one may operate a motor vehicle repair shop without a DMV-issued new car dealer's, used car dealer's, repairer's, or limited repairer's license (CGS § 14-52). A "motor vehicle repair shop" means a new car dealer, a used car dealer, a repairer, or a limited repairer (CGS § 14-65e).

Captive Insurance Company (PA 08-127)

Effective January 1, 2009, the law permits a captive insurance company to be licensed and domiciled in Connecticut to transact life insurance, annuity, health insurance, and commercial risk insurance business. A captive insurance company is, in its simplest form, an insurance company that is a wholly-owned subsidiary whose primary function is to insure all or part of the risks of its parent company.

The law enumerates requirements for a Connecticut-domiciled captive's formation, capital and surplus, local office presence, ability to meet policy obligations, payment of certain fees and premium taxes, and annual reporting, among other things.

A captive domiciled outside of Connecticut may conduct business in Connecticut, subject to conditions specified in federal and state laws.

A company's domicile is the jurisdiction under whose laws the company is organized and in which it has its principal place of business.

Related Bills

sHB 5021. The Insurance and Real Estate Committee favorably

reported sHB 5021 (File 34), which (1) increases the annual coverage maximum for ostomy-related supplies to \$5,000 from \$1,000 and (2) as with this bill, extends the requirement to policies amended in Connecticut.

sHB 5673. The Insurance and Real Estate Committee favorably reported sHB 5673 (File 11), which (1) expands current law regarding health insurance coverage for wigs and (2) as with this bill, applies certain insurance coverage requirements (i.e., treatment of tumors and leukemia, reconstructive surgery, nondental prosthesis, chemotherapy, and wigs for chemotherapy patients) to policies renewed, amended, or continued in Connecticut.

sSB 457. The Insurance and Real Estate Committee favorably reported sSB 457 (File 241), which requires all repair shops to obtain a customer’s written acknowledgement that he or she is aware of his or her right to choose the licensed repair shop that will repair his or her vehicle.

sHB 6354. The Insurance and Real Estate Committee favorably reported sHB 6354 (File 260), which (1) requires the insurance commissioner to notify the courts and police departments of any change in a surety bail bond agent’s principal business address or telephone number and (2) as with this bill, eliminates the class D felony penalty if the commissioner fails to provide them a list of surety bail bond agents or changes to the list.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 18 Nay 0 (03/12/2009)

Transportation Committee

Joint Favorable
Yea 33 Nay 1 (04/14/2009)