



# STATE OF CONNECTICUT

## INSURANCE DEPARTMENT

### Testimony of the Connecticut Insurance Department

Before the  
Insurance and Real Estate Committee

Tuesday, February 10th, 2009

#### **Raised Bill 823—An Act Concerning Revisions to the Insurance Statutes**

Raised Bill 823 is a proposal that has been introduced at the request of the Connecticut Insurance Department. The Department would like to thank the Committee for introducing this initiative on our behalf. This bill modifies various insurance statutes to strengthen the Department's ability to regulate the industry and protect consumers.

The more substantive changes include:

- Permitting the Commissioner to expand the categories of regulated entities for which consultants can be hired. Consultants are used to assist the Department in conducting exams and investigations and the cost of hiring consultants will be at the expense of the regulated entity. (Section 1)
- Increasing the filing fee on out-of-state (foreign) agent appointments from \$20.00 to \$40.00 per appointment. This change makes the filing fee for out-of-state appointments consistent with the filing fee for in-state (domestic) agent appointments and would result in an approximate \$9 million increase in general fund revenues.

*The Department would like to take this opportunity to urge your support for the Governor's recently introduced proposal (SB 837, Section 248) that would increase both domestic and foreign agent appointment fees to \$80.00.*

*The Department would also like to point out to the Committee that the language in S. 823, as drafted, does not include the increase in the filing fee that the Department had requested. (Section 3)*

- Adding new categories of health insurance for travel and single service health coverage. This change will allow affordable products to be sold that supplement medical insurance without requiring coverage for mandates that are already covered under basic medical insurance. Travel insurance is coverage for the term of a trip and may cover out of country expenses that are generally excluded on basic medical insurance policies. (Section 7)
- Permitting the Commissioner to have bail bond licensees pay for the costs of any examination of the books and records of the bail bond licensee. (Section 12)

- Revising the prompt pay statutes to clarify that they apply to both Connecticut licensed providers and those providers licensed in other states. (see attached Attorney General Opinion 2008-15) (Section 13)
- Authorizing the Commissioner to access outside consultants that are not part of the Insurance Department staff, at the expense of Connecticut captive insurer, in order to assist in the financial analysis of the captive insurer (Section 14)

The technical changes include:

- Revising the organizational structure of the Department and eliminating outdated and improperly named division references. These changes are being made at the request of the Regulations Review committee in response to action taken on August 28, 2008, regarding Regulation No. 2008-15a. (Section 2)
- Increasing the filing fees from \$20.00 to \$50.00 for the claimant and from \$20.00 to \$100.00 for the insurance company for the arbitration procedures for the settlement of disputes for automobile physical/property damage liability claims. (Section 2)
- Requiring a filing fee of \$2500 by domestic insurers when submitting applications for change of control by merger or acquisition. These filings require considerable staff resources and can, often times, be withdrawn or rescinded by the applicant. This filing fee is intended to reflect the costs of the review and current law does not impose any filing fee. (Section 3)
- Including health care centers under the Commissioner's authority to order holding company entities to produce any books and records that need to be examined under the financial examination authority of 38a-14 and the market conduct authority of 38a-15. Although most, if not all, health care centers comply with this requirement, the statutory authority needs to be explicit.

*We believe there was an inadvertent deletion referencing holding company registration when the Legislative Commissioner's Office drafted this bill (see section 4, line 295) This changes the intent of the statute and we believe the reference to section 38a-135 needs to be restored. (Section 4)*

- Amending the Market Conduct Statute to parallel the Financial Exam Statute with respect to exam costs, the use of consultants, payment for out-of-state travel and workpaper confidentiality. (Section 5)
- Providing explicit authority to the Commissioner to require carriers to publish guidelines, illustrations, disclosures, and other revisions to policy forms (contracts) and advertising and sales materials when further disclosure is in the best interest of the consumer. (Sections 6, 8 and 10)

*Please note that the Department had requested to substitute the word "order" for "decision" in section 6, lines 430 and 435. We believe these changes were overlooked in the drafting process.*

- Deleting a reference to Medicare Supplement products that are outdated and no longer being marketed. Medicare Supplement products are standardized by Federal law and the states are required to follow the federal standards. New plans have been introduced and others will be prohibited beginning in 2010. This change deletes references to any specific plans so the new plans can be sold in Connecticut and that the state is in compliance with Federal law. (Section 9)
- Clarifying long term disability offset provisions to specify that only other benefits as a result of the disability may be offset under the group long term disability policy, and not any other benefits, such as pension benefits. The Department's proposal also provides that, after the claim begins, no increases in disability benefits from any source may be offset. (Section 11)

Finally, the Insurance Department requests the Committee's indulgence to add an additional section in Raised Bill 823 to correct an incorrect citation within a statute governing the Connecticut Life and Health Insurance Guaranty Association. The reference in Section 38a-860(g)(2)(D)(ii) to Section 38a-860(f)(2) should have referenced Section 38a-860(g)(2)(B).

Our amendment modifies the incorrect citation which concerns the coverage obligations of the Association related to participants in government deferred compensation plans. This amendment corrects the citation error and allows our law to track precisely with the NAIC Model Act. The text of this amendment to Subsection (g) of Section 38a-860 is attached to this testimony and we hope it will be incorporated into a proposed substitute for Raised Bill 823.

The Department again, thanks the Committee for raising this bill and encourages the Committee's support of this initiative. We would be happy to answer any questions you may have.

## CONNECTICUT INSURANCE DEPARTMENT

### **Raised Bill 823--An Act Concerning Revisions to the Insurance Statutes**

#### **Proposed Amendment to Raised Bill 823:**

Subsection (g) of section 38a-860 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2009*):

(g) The benefits for which the association may become liable shall in no event exceed the lesser of: (1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired insurer, or (2) (A) with respect to any one life, regardless of the number of policies or contracts: (i) Five hundred thousand dollars in life insurance death benefits, but no more than five hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance; (ii) five hundred thousand dollars in health insurance benefits, including, but not limited to, any net cash surrender and net cash withdrawal values; (iii) five hundred thousand dollars in the present value of annuity benefits, including, but not limited to, net cash surrender and net cash withdrawal values; (B) with respect to each individual participating in a governmental retirement plan established under Section 401, 403(b) or 457 of the United States Internal Revenue Code of 1986, or any subsequent internal revenue code of the United States, as amended from time to time, covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, five hundred thousand dollars in present value annuity benefits, including, but not limited to, net cash surrender and net cash withdrawal values; (C) with respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, five hundred thousand dollars in present value annuity benefits, in the aggregate, including, but not limited to, net cash surrender and net cash withdrawal values, if any, provided in no event shall the association be liable to expend (i) more than the five hundred thousand dollars in the aggregate with respect to any one individual under subparagraphs (A), (B) and (C) of this subdivision, and (ii) with respect to one owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than five million dollars in benefits, regardless of the number of policies and contracts held by the owner; (D) with respect to either (i) one contract owner provided coverage under subparagraph (B) of subdivision (2) of subsection (b) of this section, or (ii) one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in [subdivision (2) of subsection (f) of this section] subparagraph (B) of subdivision (2) of this subsection, five million dollars in benefits regardless of the number of contracts with respect to the contract owner or plan sponsor, except that in the case where one or more unallocated annuity contracts are covered contracts under sections 38a-858 to 38a-875, inclusive, and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state and in no event shall the association be obligated to cover more than five million dollars in benefits with respect to all such unallocated contracts.

CT Attorney General  
Attorney General's Opinion

**Attorney General, Richard Blumenthal**

**September 22, 2008**

Honorable Thomas R. Sullivan  
Insurance Commissioner  
State of Connecticut  
P.O. Box 816  
Hartford, CT 06142-0816

Dear Commissioner Sullivan:

You have asked for our opinion on whether the provisions of Conn. Gen. Stat. § 38a-816(15) apply to out-of-state health care providers who provide health care to Connecticut residents. That statute requires health insurance companies to make timely payment to health care providers and imposes a fifteen per cent late charge on bills that are not timely paid. It is my opinion that you should seek legislative clarification of this issue because past legislative amendments to Section 38a-816(15) can be interpreted to both expand and limit the scope of that statute's protection.

According to the information supplied by your Department, the Insurance Department has interpreted Conn. Gen. Stat. § 38a-816(15) to require insurance companies to make timely payment to Connecticut and out-of-state health care providers who provide health services to Connecticut residents. Any insurance company that fails to make timely payment as set forth in the statute is required to pay interest "at the rate of fifteen per cent per annum."

Prior to 2001, there was no definition of "health care provider" contained in Section 38a-816(15). In 2001, the General Assembly enacted Public Act 01-111 amending Conn. Gen. Stat. § 38a-816(15) to define the term "health care provider" to include those categories of health care services contained in "chapter 368v, chapters 370 to 373, inclusive, 375 to 383c, inclusive, or chapter 400j." Public Act 01-111. That definition was codified as Conn. Gen. Stat. § 38a-816(15)(C). The new definition of "health care provider" substantially expanded the categories of health care providers who would be covered by the timely payment and interest provisions of Section 38a-816(15). According to its legislative history, Public Act 01-111 was intended "to expand the definition of medical providers so it is no longer just physicians but a number of medical providers...." H. Rep., at 4680(May 29,2001)(remarks of Rep. Cleary); see also S. Rep., at 1754 (remarks of Sen. Harp)("We haven't defined health care provider and this bill defines health care provider and specifies which providers are (sic), for the purposes of prompt payment claims, will be included.")

Although Public Act 01-111 expanded the categories of health care providers

covered by Section 38a-816(15), the Public Act included within the definition of health care provider the words "person licensed to provide health care services" under the cited Connecticut licensing statutes. The question has now been raised whether Conn. Gen. Stat. § 38a-816(15) only applies to health care providers who are licensed in Connecticut or whether it also applies to health care providers within the categories of health care providers set forth in Section 38a-816(15)(C) who are licensed in other states .

Your Department had construed Section 38a-816(15) as applying to in-state and out-of-state health care providers. Because the legislature through Public Act 01-111 intended to expand the categories of health care providers protected by Section 38a-816(15), it is reasonable to believe that the legislature did not intend Public Act 01-111 to limit the provisions of that statute to health care providers licensed in Connecticut. Nevertheless, Section 381-816(15)(C) can be read to provide such a limitation.

I recommend that you seek legislative clarification of whether Public Act 01-111 intended the protections afforded by Section 38a-816(15) to apply to health care providers licensed in Connecticut and other states who provide Connecticut residents the types of health care services set forth in Section 38a-816(15)(C).

Clearly, there are strong public policy reasons for ensuring that all health care providers who provide health care services to Connecticut residents receive timely payment for their services. I would be pleased to work with you on this matter.

Very truly yours,

RICHARD BLUMENTHAL  
ATTORNEY GENERAL