



General Assembly

**Amendment**

January Session, 2009

LCO No. 6536

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Offered by:

REP. FONTANA, 87<sup>th</sup> Dist.

SEN. CRISCO, 17<sup>th</sup> Dist.

To: Subst. House Bill No. 6527

File No. 312

Cal. No. 250

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

1 Strike lines 4 to 6, inclusive, in their entirety and insert the following  
2 in lieu thereof:

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

7 After the last section, add the following and renumber sections and  
8 internal references accordingly:

9 "Sec. 501. Section 38a-91k of the general statutes is repealed and the  
10 following is substituted in lieu thereof (*Effective from passage*):

11 Each captive insurer that is domiciled in another state and offers,  
12 renews or continues insurance in this state shall provide the  
13 information described in subdivisions (1) to (3), inclusive, of

14 subsection (a) of section 38a-253 to the Insurance Commissioner in the  
15 same manner required for risk retention groups. If a captive insurer  
16 does not maintain information in the form prescribed in section 38a-  
17 253, the captive insurer may submit the information to the Insurance  
18 Commissioner on such form as the commissioner prescribes. As used  
19 in this section and section 38a-25, "captive insurer" means an insurance  
20 company owned by another organization whose primary purpose is to  
21 insure risks of a parent organization or affiliated persons, as defined in  
22 section 38a-1, or in the case of groups and associations, an insurance  
23 organization owned by the insureds whose primary purpose is to  
24 insure risks of member organizations and group members and their  
25 affiliates.

26 Sec. 502. Section 38a-491a of the general statutes is repealed and the  
27 following is substituted in lieu thereof (*Effective January 1, 2010*):

28 (a) Each individual health insurance policy providing coverage of  
29 the type specified in subdivisions (1), (2), (4), (11) and (12) of section  
30 38a-469 delivered, issued for delivery, renewed, amended or continued  
31 in this state [on or after January 1, 2000,] shall provide coverage for  
32 general anesthesia, nursing and related hospital services provided in  
33 conjunction with in-patient, outpatient or one-day dental services if the  
34 following conditions are met:

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

39 (2) The patient is either (A) determined by a licensed dentist, in  
40 conjunction with a licensed physician who specializes in primary care,  
41 to have a dental condition of significant dental complexity that it  
42 requires certain dental procedures to be performed in a hospital, or (B)  
43 a person who has a developmental disability, as determined by a  
44 licensed physician who specializes in primary care, that places the  
45 person at serious risk.

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

50 Sec. 503. Section 38a-556 of the general statutes is repealed and the  
51 following is substituted in lieu thereof (*Effective from passage*):

52 There is hereby created a nonprofit legal entity to be known as the  
53 Health Reinsurance Association. All insurers, health care centers and  
54 self-insurers doing business in the state, as a condition to their  
55 authority to transact the applicable kinds of health insurance defined  
56 in section 38a-551, shall be members of the association. The association  
57 shall perform its functions under a plan of operation established and  
58 approved under subdivision (a) of this section, and shall exercise its  
59 powers through a board of directors established under this section.

60 (a) (1) The board of directors of the association shall be made up of  
61 nine individuals selected by participating members, subject to  
62 approval by the commissioner, two of whom shall be appointed by the  
63 commissioner on or before July 1, 1993, to represent health care  
64 centers. To select the initial board of directors, and to initially organize  
65 the association, the commissioner shall give notice to all members of  
66 the time and place of the organizational meeting. In determining  
67 voting rights at the organizational meeting each member shall be  
68 entitled to vote in person or proxy. The vote shall be a weighted vote  
69 based upon the net health insurance premium derived from this state  
70 in the previous calendar year. If the board of directors is not selected  
71 within sixty days after notice of the organizational meeting, the  
72 commissioner may appoint the initial board. In approving or selecting  
73 members of the board, the commissioner may consider, among other  
74 things, whether all members are fairly represented. Members of the  
75 board may be reimbursed from the moneys of the association for  
76 expenses incurred by them as members, but shall not otherwise be  
77 compensated by the association for their services. (2) The board shall  
78 submit to the commissioner a plan of operation for the association

79 necessary or suitable to assure the fair, reasonable and equitable  
80 administration of the association. The plan of operation shall become  
81 effective upon approval in writing by the commissioner consistent  
82 with the date on which the coverage under sections 38a-505, 38a-546  
83 and 38a-551 to 38a-559, inclusive, must be made available. The  
84 commissioner shall, after notice and hearing, approve the plan of  
85 operation provided such plan is determined to be suitable to assure the  
86 fair, reasonable and equitable administration of the association, and  
87 provides for the sharing of association gains or losses on an equitable  
88 proportionate basis. If the board fails to submit a suitable plan of  
89 operation within one hundred eighty days after its appointment, or if  
90 at any time thereafter the board fails to submit suitable amendments to  
91 the plan, the commissioner shall, after notice and hearing, adopt and  
92 promulgate such reasonable rules as are necessary or advisable to  
93 effectuate the provisions of this section. Such rules shall continue in  
94 force until modified by the commissioner or superseded by a plan  
95 submitted by the board and approved by the commissioner. The plan  
96 of operation shall, in addition to requirements enumerated in sections  
97 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive: (A) Establish  
98 procedures for the handling and accounting of assets and moneys of  
99 the association; (B) establish regular times and places for meetings of  
100 the board of directors; (C) establish procedures for records to be kept  
101 of all financial transactions, and for the annual fiscal reporting to the  
102 commissioner; (D) establish procedures whereby selections for the  
103 board of directors shall be made and submitted to the commissioner;  
104 (E) establish procedures to amend, subject to the approval of the  
105 commissioner, the plan of operations; (F) establish procedures for the  
106 selection of an [administering carrier] administrator and set forth the  
107 powers and duties of the [administering carrier] administrator; (G)  
108 contain additional provisions necessary or proper for the execution of  
109 the powers and duties of the association; (H) establish procedures for  
110 the advertisement on behalf of all participating carriers of the general  
111 availability of the comprehensive coverage under sections 38a-505,  
112 38a-546 and 38a-551 to 38a-559, inclusive; (I) contain additional  
113 provisions necessary for the association to qualify as an acceptable

114 alternative mechanism in accordance with Section 2744 of the Public  
115 Health Service Act, as set forth in the Health Insurance Portability and  
116 Accountability Act of 1996, [(P.L. 104-191)] P.L. 104-191; and (J) contain  
117 additional provisions necessary for the association to qualify as  
118 acceptable coverage in accordance with the Pension Benefit Guaranty  
119 Corporation and Trade Adjustment Assistance programs of the Trade  
120 Act of 2002, [(P.L. 107-210)] P.L. 107-210. The commissioner may adopt  
121 regulations, in accordance with the provisions of chapter 54, to  
122 establish criteria for the association to qualify as an acceptable  
123 alternative mechanism.

124 (b) The association shall have the general powers and authority  
125 granted under the laws of this state to carriers to transact the kinds of  
126 insurance defined under section 38a-551, and in addition thereto, the  
127 specific authority to: (1) Enter into contracts necessary or proper to  
128 carry out the provisions and purposes of sections 38a-505, 38a-546 and  
129 38a-551 to 38a-559, inclusive; (2) sue or be sued, including taking any  
130 legal actions necessary or proper for recovery of any assessments for,  
131 on behalf of, or against participating members; (3) take such legal  
132 action as necessary to avoid the payment of improper claims against  
133 the association or the coverage provided by or through the association;  
134 (4) establish, with respect to health insurance provided by or on behalf  
135 of the association, appropriate rates, scales of rates, rate classifications  
136 and rating adjustments, such rates not to be unreasonable in relation to  
137 the coverage provided and the operational expenses of the association;  
138 (5) administer any type of reinsurance program, for or on behalf of  
139 participating members; (6) pool risks among participating members;  
140 (7) issue policies of insurance on an indemnity or provision of service  
141 basis providing the coverage required by sections 38a-505, 38a-546 and  
142 38a-551 to 38a-559, inclusive, in its own name or on behalf of  
143 participating members; (8) administer separate pools, separate  
144 accounts or other plans as deemed appropriate for separate members  
145 or groups of members; (9) operate and administer any combination of  
146 plans, pools, reinsurance arrangements or other mechanisms as  
147 deemed appropriate to best accomplish the fair and equitable

148 operation of the association; (10) set limits on the amounts of  
149 reinsurance [which] that may be ceded to the association by its  
150 members; (11) appoint from among participating members appropriate  
151 legal, actuarial and other committees as necessary to provide technical  
152 assistance in the operation of the association, policy and other contract  
153 design, and any other function within the authority of the association;  
154 and (12) apply for and accept grants, gifts and bequests of funds from  
155 other states, federal and interstate agencies and independent  
156 authorities, private firms, individuals and foundations for the purpose  
157 of carrying out its responsibilities. Any such funds received shall be  
158 deposited in the General Fund and shall be credited to a separate  
159 nonlapsing account within the General Fund for the Health  
160 Reinsurance Association and may be used by the Health Reinsurance  
161 Association in the performance of its duties.

162 (c) Every member shall participate in the association in accordance  
163 with the provisions of this subdivision. (1) A participating member  
164 shall determine the particular risks it elects to have written by or  
165 through the association. A member shall designate which of the  
166 following classes of risks it shall underwrite in the state, from which  
167 classes of risk it may elect to reinsure selected risks: (A) Individual,  
168 excluding group conversion; and (B) individual, including group  
169 conversion. (2) No member shall be permitted to select out individual  
170 lives from an employer group to be insured by or through the  
171 association. Members electing to administer risks [which] that are  
172 insured by or through the association shall comply with the benefit  
173 determination guidelines and the accounting procedures established  
174 by the association. A risk insured by or through the association cannot  
175 be withdrawn by the participating member except in accordance with  
176 the rules established by the association. (3) Rates for coverage issued  
177 by or through the association shall not be excessive, inadequate or  
178 unfairly discriminatory. Separate scales of premium rates based on age  
179 shall apply, but rates shall not be adjusted for area variations in  
180 provider costs. Premium rates shall take into consideration the  
181 substantial extra morbidity and administrative expenses for

182 association risks, reimbursement or reasonable expenses incurred for  
183 the writing of association risks and the level of rates charged by  
184 insurers for groups of ten lives, provided incurred losses [which] that  
185 result from provision of coverage in accordance with section 38a-537  
186 shall not be considered. In no event shall the rate for a given  
187 classification or group be less than one hundred twenty-five per cent  
188 or more than one hundred fifty per cent of the average rate charged for  
189 that classification with similar characteristics under a policy covering  
190 ten lives. All rates shall be promulgated by the association through an  
191 actuarial committee consisting of five persons who are members of the  
192 American Academy of Actuaries, shall be filed with the commissioner  
193 and may be disapproved within sixty days from the filing thereof if  
194 excessive, inadequate or unfairly discriminatory.

195 (d) (1) Following the close of each fiscal year, the [administering  
196 carrier] administrator shall determine the net premiums, reinsurance  
197 premiums less administrative expense allowance, the expense of  
198 administration pertaining to the reinsurance operations of the  
199 association and the incurred losses for the year. Any net loss shall be  
200 assessed to all participating members in proportion to their respective  
201 shares of the total health insurance premiums earned in this state  
202 during the calendar year, or with paid losses in the year, coinciding  
203 with or ending during the fiscal year of the association or on any other  
204 equitable basis as may be provided in the plan of operations. For self-  
205 insured members of the association, health insurance premiums  
206 earned shall be established by dividing the amount of paid health  
207 losses for the applicable period by eighty-five per cent. Net gains, if  
208 any, shall be held at interest to offset future losses or allocated to  
209 reduce future premiums. (2) Any net loss to the association  
210 represented by the excess of its actual expenses of administering  
211 policies issued by the association over the applicable expense  
212 allowance shall be separately assessed to those participating members  
213 who do not elect to administer their plans. All assessments shall be on  
214 an equitable formula established by the board. (3) The association shall  
215 conduct periodic audits to assure the general accuracy of the financial

216 data submitted to the association and the association shall have an  
217 annual audit of its operations by an independent certified public  
218 accountant. The annual audit shall be filed with the commissioner for  
219 his review and the association shall be subject to the provisions of  
220 section 38a-14. (4) For the fiscal year ending December 31, 1993, and  
221 the first quarter of the fiscal year ending December 31, 1994, the  
222 [administering carrier] administrator shall not include health care  
223 centers in assessing any net losses to participating members.

224 (e) All policy forms issued by or through the association shall  
225 conform in substance to prototype forms developed by the association,  
226 shall in all other respects conform to the requirements of sections 38a-  
227 505, 38a-546 and 38a-551 to 38a-559, inclusive, and shall be approved  
228 by the commissioner. The commissioner may disapprove any such  
229 form if it contains a provision or provisions which are unfair or  
230 deceptive or which encourage misrepresentation of the policy.

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

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

245 (h) There shall be no liability on the part of and no cause of action of  
246 any nature shall arise against any carrier or its agents or its employees,  
247 the Health Reinsurance Association or its agents or its employees or

248 the residual market mechanism established under the provisions of  
249 section 38a-557 or its agents or its employees, or the commissioner or  
250 his representatives for any action taken by them in the performance of  
251 their duties under sections 38a-505, 38a-546 and 38a-551 to 38a-559,  
252 inclusive. This provision shall not apply to the obligations of a carrier,  
253 a self-insurer, the Health Reinsurance Association or the residual  
254 market mechanism for payment of benefits provided under a  
255 comprehensive health care plan.

256 Sec. 504. Section 38a-569 of the general statutes is repealed and the  
257 following is substituted in lieu thereof (*Effective from passage*):

258 (a) (1) There is established a nonprofit entity to be known as the  
259 "Connecticut Small Employer Health Reinsurance Pool". All insurers  
260 issuing health insurance in this state and insurance arrangements  
261 providing health plan benefits in this state on and after July 1, 1990,  
262 shall be members of the pool.

263 (2) On or before July 15, 1990, the commissioner shall give notice to  
264 all insurers and insurance arrangements of the time and place for the  
265 initial organizational meeting, which shall take place by September 1,  
266 1990. The members shall select the initial board, subject to approval by  
267 the commissioner. The board shall consist of at least five and not more  
268 than nine representatives of members. There shall be no more than two  
269 members of the board representing any one insurer or insurance  
270 arrangement. In determining voting rights at the organizational  
271 meeting, each member shall be entitled to vote in person or by proxy.  
272 The vote shall be weighted based upon net health insurance premium  
273 derived from this state in the previous calendar year. To the extent  
274 possible, at least one-third of the members of the board shall be  
275 domestic insurance companies and at least two-thirds of the members  
276 of the board shall be small employer carriers. At least one member of  
277 the board shall be a health care center and at least one member shall be  
278 a small employer carrier with less than one hundred million dollars in  
279 net small employer health insurance premium in this state. The  
280 Insurance Commissioner shall be an ex-officio member of the board.

281 The net premium amount shall be adjusted by the board periodically  
282 for health care cost inflation. In approving selection of the board, the  
283 commissioner shall assure that all members are fairly represented. The  
284 membership of all boards subsequent to the initial board shall, to the  
285 extent possible, reflect the same distribution of representation as is  
286 described in this subdivision.

287 (3) If the initial board is not elected at the organizational meeting,  
288 the commissioner shall appoint the initial board within fifteen days of  
289 the organizational meeting.

290 (4) Within ninety days after the appointment of such initial board,  
291 the board shall submit to the commissioner a plan of operation and  
292 thereafter any amendments thereto necessary or suitable to assure the  
293 fair, reasonable and equitable administration of the pool. The  
294 commissioner shall, after notice and hearing, approve the plan of  
295 operation provided he determines it to be suitable to assure the fair,  
296 reasonable and equitable administration of the pool, and provides for  
297 the sharing of pool gains or losses on an equitable proportionate basis  
298 in accordance with the provisions of subsection (d) of this section. The  
299 plan of operation shall become effective upon approval in writing by  
300 the commissioner consistent with the date on which the coverage  
301 under this section shall be made available. If the board fails to submit a  
302 suitable plan of operation within one hundred eighty days after its  
303 appointment, or at any time thereafter fails to submit suitable  
304 amendments to the plan of operation, the commissioner shall, after  
305 notice and hearing, adopt and promulgate a plan of operation or  
306 amendments, as appropriate. The commissioner shall amend any plan  
307 adopted by him, as necessary, at the time a plan of operation is  
308 submitted by the board and approved by the commissioner.

309 (5) The plan of operation shall establish procedures for: (A)  
310 Handling and accounting of assets and moneys of the pool, and for an  
311 annual fiscal reporting to the commissioner; (B) filling vacancies on the  
312 board, subject to the approval of the commissioner; (C) selecting an  
313 [administering insurer] administrator and setting forth the powers and

314 duties of the [administering insurer] administrator; (D) reinsuring risks  
315 in accordance with the provisions of this section; (E) collecting  
316 assessments from all members to provide for claims reinsured by the  
317 pool and for administrative expenses incurred or estimated to be  
318 incurred during the period for which the assessment is made and (F)  
319 any additional matters at the discretion of the board.

320 (6) The pool shall have the general powers and authority granted  
321 under the laws of Connecticut to insurance companies licensed to  
322 transact health insurance and, in addition thereto, the specific  
323 authority to: (A) Enter into contracts as are necessary or proper to  
324 carry out the provisions and purposes of this section, including the  
325 authority, with the approval of the commissioner, to enter into  
326 contracts with programs of other states for the joint performance of  
327 common functions, or with persons or other organizations for the  
328 performance of administrative functions; (B) sue or be sued, including  
329 taking any legal actions necessary or proper for recovery of any  
330 assessments for, on behalf of, or against members; (C) take such legal  
331 action as necessary to avoid the payment of improper claims against  
332 the pool; (D) define the array of health coverage products for which  
333 reinsurance will be provided, and to issue reinsurance policies, in  
334 accordance with the requirements of this section; (E) establish rules,  
335 conditions and procedures pertaining to the reinsurance of members'  
336 risks by the pool; (F) establish appropriate rates, rate schedules, rate  
337 adjustments, rate classifications and any other actuarial functions  
338 appropriate to the operation of the pool; (G) assess members in  
339 accordance with the provisions of subsection (e) of this section, and to  
340 make advance interim assessments as may be reasonable and  
341 necessary for organizational and interim operating expenses. Any such  
342 interim assessments shall be credited as offsets against any regular  
343 assessments due following the close of the fiscal year; (H) appoint from  
344 among members appropriate legal, actuarial and other committees as  
345 necessary to provide technical assistance in the operation of the pool,  
346 policy and other contract design, and any other function within the  
347 authority of the pool; and (I) borrow money to effect the purposes of

348 the pool. Any notes or other evidence of indebtedness of the pool not  
349 in default shall be legal investments for insurers and may be carried as  
350 admitted assets.

351 (b) Any member may reinsure with the pool coverage of an eligible  
352 employee of a small employer, or any dependent of such an employee,  
353 except that no member may reinsure with the pool coverage of an  
354 eligible employee of a small employer, or any dependent of such an  
355 employee, whose premium rates are not subject to section 38a-567  
356 pursuant to subdivision (22) of section 38a-567. Any reinsurance  
357 placed with the pool from the date of the establishment of the pool  
358 regarding the coverage of an eligible employee of a small employer, or  
359 any dependent of such an employee shall be provided as follows:

360 (1) (A) With respect to a special health care plan or a small employer  
361 health care plan, the pool shall reinsure the level of coverage provided;  
362 (B) with respect to other plans, the pool shall reinsure the level of  
363 coverage provided up to, but not exceeding, the level of coverage  
364 provided in a small employer health care plan or the actuarial  
365 equivalent thereof as defined and authorized by the board; and (C) in  
366 either case, no reinsurance may be provided in any calendar year for a  
367 reinsured employee or dependent until five thousand dollars in benefit  
368 payments have been made for services provided during that calendar  
369 year for that reinsured employee or dependent, which payments  
370 would have been reimbursed through said reinsurance in the absence  
371 of the annual five-thousand-dollar deductible. The amount of the  
372 deductible shall be periodically reviewed by the board and may be  
373 adjusted for appropriate factors as determined by the board;

374 (2) With respect to eligible employees, and their dependents,  
375 coverage may be reinsured: (A) Within such period of time after the  
376 commencement of their coverage under the plan as may be authorized  
377 by the board, or (B) commencing January 1, 1992, on the first plan  
378 anniversary after the employer's coverage has been in effect with the  
379 small employer carrier for a period of three years, and every third plan  
380 anniversary thereafter, provided, commencing May 1, 1994,

381 reinsurance pursuant to this subparagraph shall only be permitted  
382 with respect to eligible employees and their dependents of a small  
383 employer which has no more than two eligible employees as of the  
384 applicable anniversary;

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

387 (4) Reinsurance of newborn dependents shall be allowed only if the  
388 mother of any such dependent is reinsured as of the date of birth of  
389 such child, and all newborn dependents of reinsured persons shall be  
390 automatically reinsured as of their date of birth; and

391 (5) Notwithstanding the provisions of subparagraph (A) of  
392 subdivision (2) of this subsection: (A) Coverage for eligible employees  
393 and their dependents provided under a group policy covering two or  
394 more small employers shall not be eligible for reinsurance when such  
395 coverage is discontinued and replaced by a group policy of another  
396 carrier covering two or more small employers, unless coverage for  
397 such eligible employees or dependents was reinsured by the prior  
398 carrier; and (B) at the time coverage is assumed for such group by a  
399 succeeding carrier, such carrier shall notify the pool of its intention to  
400 provide coverage for such group and shall identify the employees and  
401 dependents whose coverage will continue to be reinsured. The time  
402 limitations for providing such notice shall be established by the pool.

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

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

411 (2) Five hundred per cent, with respect to an eligible employee or

412 dependent who is individually reinsured in accordance with  
413 subdivision (2) of subsection (b) of this section and is not reinsured  
414 with all eligible employees of an employer and their dependents.

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

421 (e) (1) Following the close of each fiscal year, the [administering  
422 insurer] administrator shall determine the net premiums, the pool  
423 expenses of administration and the incurred losses for the year, taking  
424 into account investment income and other appropriate gains and  
425 losses. For purposes of this section, health insurance premiums earned  
426 by insurance arrangements shall be established by adding paid health  
427 losses and administrative expenses of the insurance arrangement.  
428 Health insurance premiums and benefits paid by a member that are  
429 less than an amount determined by the board to justify the cost of  
430 collection shall not be considered for purposes of determining  
431 assessments. For the purposes of this subsection, "net premiums"  
432 means health insurance premiums, less administrative expense  
433 allowances.

434 (2) Any net loss for the year shall be recouped by assessments of  
435 members. (A) Assessments shall first be apportioned by the board  
436 among all members in proportion to their respective shares of the total  
437 health insurance premiums earned in this state from health insurance  
438 plans and insurance arrangements covering small employers during  
439 the calendar year coinciding with or ending during the fiscal year of  
440 the pool, or on any other equitable basis reflecting coverage of small  
441 employers as may be provided in the plan of operations. An  
442 assessment shall be made pursuant to this subparagraph against a  
443 health care center, which is approved by the Secretary of Health and  
444 Human Services as a health maintenance organization pursuant to 42

445 USC 300e et seq., as amended from time to time, subject to an  
446 assessment adjustment formula adopted by the board and approved  
447 by the commissioner for such health care centers, which recognizes the  
448 restrictions imposed on such health care centers by federal law. Such  
449 adjustment formula shall be adopted by the board and approved by  
450 the commissioner prior to the first anniversary of the pool's operation.  
451 (B) If such net loss is not recouped before assessments totaling five per  
452 cent of such premiums from plans and arrangements covering small  
453 employers have been collected, additional assessments shall be  
454 apportioned by the board among all members in proportion to their  
455 respective shares of the total health insurance premiums earned in this  
456 state from other individual and group plans and arrangements,  
457 exclusive of any individual Medicare supplement policies as defined in  
458 section 38a-495 during such calendar year. (C) Notwithstanding the  
459 provisions of this subdivision, the assessments to any one member  
460 under subparagraph (A) or (B) of this subdivision shall not exceed  
461 forty per cent of the total assessment under each subparagraph for the  
462 first fiscal year of the pool's operation and fifty per cent of the total  
463 assessment under each subparagraph for the second fiscal year. Any  
464 amounts abated pursuant to this subparagraph shall be assessed  
465 against the other members in a manner consistent with the basis for  
466 assessments set forth in this subdivision.

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

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

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

480 (6) The board may defer, in whole or in part, the assessment of a  
481 health care center if, in the opinion of the board: (A) Payment of the  
482 assessment would endanger the ability of the health care center to  
483 fulfill its contractual obligations, or (B) in accordance with standards  
484 included in the plan of operation, the health care center has written,  
485 and reinsured in their entirety, a disproportionate number of special  
486 health care plans. In the event an assessment against a health care  
487 center is deferred in whole or in part, the amount by which such  
488 assessment is deferred may be assessed against the other members in a  
489 manner consistent with the basis for assessments set forth in this  
490 subsection. The health care center receiving such deferment shall  
491 remain liable to the pool for the amount deferred. The board may  
492 attach appropriate conditions to any such deferment.

493 (f) (1) Neither the participation in the pool as members, the  
494 establishment of rates, forms or procedures nor any other joint or  
495 collective action required by this section shall be the basis of any legal  
496 action, criminal or civil liability or penalty against the pool or any of its  
497 members.

498 (2) Any person or member made a party to any action, suit [,] or  
499 proceeding because the person or member served on the board or on a  
500 committee or was an officer or employee of the pool shall be held  
501 harmless and be indemnified by the program against all liability and  
502 costs, including the amounts of judgments, settlements, fines or  
503 penalties, and expenses and reasonable attorney's fees incurred in  
504 connection with the action, suit or proceeding. The indemnification  
505 shall not be provided on any matter in which the person or member is  
506 finally adjudged in the action, suit or proceeding to have committed a  
507 breach of duty involving gross negligence, dishonesty, wilful  
508 misfeasance or reckless disregard of the responsibilities of office. Costs  
509 and expenses of the indemnification shall be prorated and paid for by  
510 all members. The Insurance Commissioner may retain actuarial

511 consultants necessary to carry out [his] said commissioner's  
512 responsibilities pursuant to sections 38a-564 to 38a-572, inclusive, and  
513 such expenses shall be paid by the pool established in this section."