



House of Representatives

General Assembly

File No. 10

February Session, 2010

House Bill No. 5006

House of Representatives, March 11, 2010

The Committee on Insurance and Real Estate reported through REP. FONTANA, S. of the 87th Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

AN ACT CONCERNING THE LEGISLATIVE COMMISSIONERS' RECOMMENDATIONS FOR TECHNICAL REVISIONS AND 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 (2) of subsection (b) of section 38a-9 of the
2 general statutes is repealed and the following is substituted in lieu
3 thereof (*Effective from passage*):

4 (2) The commissioner shall prepare a list of at least ten persons, who
5 have not been employed by the department or an insurance company
6 during the preceding twelve months, to serve as arbitrators in the
7 settlement of such disputes. The arbitrators shall be members of any
8 dispute resolution organization approved by the commissioner. One
9 arbitrator shall be appointed to hear and decide each complaint.
10 Appointment shall be based solely on the order of the list. If an
11 arbitrator is unable to serve on a given day, or if either party objects to
12 the arbitrator, then the next arbitrator on the list [will] shall be selected.
13 The department shall schedule arbitration hearings as often, and in

14 such locations, as it deems necessary. Parties to the dispute shall be
15 provided written notice of the hearing [.] at least ten days prior to the
16 hearing date. The commissioner may issue subpoenas on behalf of the
17 arbitrator to compel the attendance of witnesses and the production of
18 documents, papers and records relevant to the dispute. Decisions shall
19 be made on the basis of the evidence presented at the arbitration
20 hearing. Where the arbitrator believes that technical expertise is
21 necessary to decide a case, [he] such arbitrator may consult with an
22 independent expert recommended by the commissioner. The arbitrator
23 and any independent technical expert shall be paid by the department
24 on a per dispute basis as established by the commissioner. The
25 arbitrator, as expeditiously as possible [.] but not later than fifteen days
26 after the arbitration hearing, shall render a written decision based on
27 the information gathered and disclose the findings and the reasons to
28 the parties involved. The arbitrator shall award filing fees to the
29 prevailing party. If the decision favors the consumer the decision shall
30 provide specific and appropriate remedies including interest at the rate
31 of ten per cent on the arbitration award concerning the disputed
32 amount of the claim, retroactive to the date of payment for the
33 undisputed amount of the claim. The decision may include costs for
34 loss of use and storage of the motor vehicle and shall specify a date for
35 performance and completion of all awarded remedies.
36 Notwithstanding any provision of the general statutes or any
37 regulation, [to the contrary,] the Insurance Department shall not
38 amend, reverse, rescind, or revoke any decision or action of any
39 arbitrator. The department shall contact the consumer [within] not
40 later than ten [working] business days after the date for performance,
41 to determine whether performance has occurred. Either party may
42 make application to the superior court for the judicial district in which
43 one of the parties resides or, when the court is not in session, any judge
44 thereof for an order confirming, vacating, modifying or correcting any
45 award, in accordance with the provisions of sections 52-417, 52-418, 52-
46 419 and 52-420. If it is determined by the court that either party's
47 position after review has been improved by at least ten per cent over
48 that party's position after arbitration, the court [, in its discretion,] may

49 grant to that party its costs and reasonable attorney's fees. No
50 evidence, testimony, findings, or decision from the department
51 arbitration procedure shall be admissible in any civil proceeding,
52 except judicial review of the arbitrator's decision as contemplated by
53 this subsection.

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

57 (15) (A) Captive insurers, as defined in section 38a-91k, as amended
58 by this act, and (B) captive insurance companies, as defined in section
59 38a-91aa, if a registered agent cannot be found with reasonable
60 diligence at the registered office of a captive insurance company.

61 Sec. 3. Subdivision (3) of subsection (b) of section 38a-55 of the
62 general statutes is repealed and the following is substituted in lieu
63 thereof (*Effective from passage*):

64 (3) In the case of a domestic life insurance company, the provisions
65 of this subsection shall apply to a separate account only to the extent
66 that reserves for guarantees with respect to (A) benefits guaranteed as
67 to dollar amount and duration or (B) funds guaranteed as to principal
68 amount or stated rate of interest are held in a separate account in
69 accordance with subdivision [(iii)] (3) of subsection (a) of section 38a-
70 433, as amended by this act.

71 Sec. 4. Subsection (c) of section 38a-60 of the general statutes is
72 repealed and the following is substituted in lieu thereof (*Effective from*
73 *passage*):

74 (c) If such emergency plan is adopted, it may provide that it will
75 become operative automatically during any such national emergency
76 and, notwithstanding any [contrary] provision of the law or the charter
77 or bylaws of the company, may contain any provisions reasonably
78 necessary for the operation of the company during any such national
79 emergency. Such provisions need not be consistent with the

80 comparable provisions stated in subsection (b) of this section. Such
81 provisions may provide, among other things, for (1) the designation of
82 persons who may call a meeting of the board of directors; (2) the
83 quorum and notice requirements for, and location of, any such
84 meeting; (3) the filling of vacancies on the board of directors; (4) a
85 succession list of persons by name or title who will succeed to
86 positions of higher rank; (5) the establishment of the principal office of
87 the company at a new location in or out of the state.

88 Sec. 5. Subsection (d) of section 38a-91ff of the general statutes is
89 repealed and the following is substituted in lieu thereof (*Effective from*
90 *passage*):

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

92 (1) [(A)] Formed as a corporation, before the articles of
93 incorporation are transmitted to the Secretary of the State, the
94 incorporators shall petition the Insurance Commissioner to issue a
95 certificate setting forth the commissioner's finding that the
96 establishment and maintenance of the proposed corporation will
97 promote the general good of the state. In arriving at such a finding the
98 commissioner shall consider:

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

101 [(ii)] (B) The character, reputation, financial responsibility, insurance
102 experience and business qualifications of the officers and directors;
103 and

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

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

108 (2) Formed as a reciprocal insurer, the organizers shall petition the
109 commissioner to issue a certificate setting forth the commissioner's

110 finding that the establishment and maintenance of the proposed
111 association will promote the general good of the state. In arriving at
112 such a finding the commissioner shall consider the items set forth in
113 [subparagraph (A) of] subdivision (1) of this subsection.

114 (3) Formed as a limited liability company, before the articles of
115 organization are transmitted to the Secretary of the State, the
116 organizers shall petition the commissioner to issue a certificate setting
117 forth the commissioner's finding that the establishment and
118 maintenance of the proposed company will promote the general good
119 of the state. In arriving at such a finding, the commissioner shall
120 consider the items set forth in [subparagraph (A) of] subdivision (1) of
121 this subsection.

122 (4) The articles of incorporation and certificate set forth in
123 subdivisions (1) to (3), inclusive, of this subsection shall be transmitted
124 to the Secretary of the State along with any fees required by the
125 Secretary of the State, who shall record both the articles of
126 incorporation and the certificate.

127 Sec. 6. Section 38a-91k of the general statutes is repealed and the
128 following is substituted in lieu thereof (*Effective from passage*):

129 Each captive insurer that is domiciled in another state and offers,
130 renews or continues insurance in this state shall provide the
131 information described in subdivisions (1) to (3), inclusive, of
132 subsection (a) of section 38a-253 to the Insurance Commissioner in the
133 same manner required for risk retention groups. If a captive insurer
134 does not maintain information in the form prescribed in section 38a-
135 253, the captive insurer may submit the information to the Insurance
136 Commissioner on such form as the commissioner prescribes. As used
137 in this section and section 38a-25, as amended by this act, "captive
138 insurer" means an insurance company owned by another organization
139 whose primary purpose is to insure risks of a parent organization or
140 affiliated persons, as defined in section 38a-1, or in the case of groups
141 and associations, an insurance organization owned by the insureds
142 whose primary purpose is to insure risks of member organizations and

143 group members and their affiliates.

144 Sec. 7. Subsection (d) of section 38a-102 of the 2010 supplement to
145 the general statutes is repealed and the following is substituted in lieu
146 thereof (*Effective from passage*):

147 (d) In the case of a domestic life insurance company, the investment
148 limitations set forth in section 38a-102c shall apply to a separate
149 account only to the extent that reserves for guarantees with respect to
150 (1) benefits guaranteed as to dollar amount and duration or (2) funds
151 guaranteed as to principal amount or stated rate of interest are held in
152 a separate account in accordance with subdivision (3) of subsection (a)
153 [(iii)] of section 38a-433, as amended by this act.

154 Sec. 8. Section 38a-307 of the 2010 supplement to the general statutes
155 is repealed and the following is substituted in lieu thereof (*Effective*
156 *January 1, 2011*):

157 Except as provided in section 38a-307a, as amended by this act, the
158 standard form of fire insurance policy of the state of Connecticut, with
159 permission to substitute for the word "Company" a more accurate
160 descriptive term of the type of insurer, shall be as follows:

161 [Space for insertion of name of company or companies issuing the
162 policy and other matter permitted to be stated at the head of the
163 policy.]

164 [Space for listing amounts of insurance, rates and premiums for the
165 basic coverages insured under the standard form of policy and for
166 additional coverages or perils insured under endorsements attached.]

188 and stipulations and those hereinafter stated, which are hereby made a
189 part of this policy, together with such other provisions, stipulations
190 and agreements as may be added hereto, as provided in this policy.

191 In Witness Whereof, this Company has executed and attested these
192 presents.

193 (Secretary).

194 (President).

195 Concealment, fraud. This entire policy shall be void if, whether
196 before or after a loss, the insured has wilfully concealed or
197 misrepresented any material fact or circumstance concerning this
198 insurance or the subject thereof, or the interest of the insured therein,
199 or in case of any fraud or false swearing by the insured relating
200 thereto.

201 Uninsurable and excepted property. This policy shall not cover
202 accounts, bills, currency, deeds, evidences of debt, money or securities;
203 nor, unless specifically named hereon in writing, bullion or
204 manuscripts.

205 Perils not included. This Company shall not be liable for loss by fire
206 or other perils insured against in this policy caused, directly or
207 indirectly, by: (a) Enemy attack by armed forces, including action
208 taken by military, naval or air forces in resisting an actual or an
209 immediately impending enemy attack; (b) invasion; (c) insurrection;
210 (d) rebellion; (e) revolution; (f) civil war; (g) usurped power; (h) order
211 of any civil authority except acts of destruction at the time of and for
212 the purpose of preventing the spread of fire, provided that such fire
213 did not originate from any of the perils excluded by this policy; (i)
214 neglect of the insured to use all reasonable means to save and preserve
215 the property at and after a loss, or when the property is endangered by
216 fire in neighboring premises; (j) nor shall this Company be liable for
217 loss by theft.

218 Other Insurance. Other insurance may be prohibited or the amount

219 of insurance may be limited by endorsement attached hereto.

220 Conditions suspending or restricting insurance. Unless otherwise
221 provided in writing added hereto this Company shall not be liable for
222 loss occurring (a) while the hazard is increased by any means within
223 the control or knowledge of the insured; or (b) while a described
224 building, whether intended for occupancy by owner or tenant, is
225 vacant or unoccupied beyond a period of sixty consecutive days; or (c)
226 as a result of explosion or riot, unless fire ensue, and in that event for
227 loss by fire only.

228 Other perils or subjects. Any other peril to be insured against or
229 subject of insurance to be covered in this policy shall be by
230 endorsement in writing hereon or added hereto.

231 Added provisions. The extent of the application of insurance under
232 this policy and of the contribution to be made by this Company in case
233 of loss, and any other provision or agreement not inconsistent with the
234 provisions of this policy, may be provided for in writing added hereto,
235 but no provision may be waived except such as by the terms of this
236 policy is subject to change.

237 Waiver provisions. No permission affecting this insurance shall
238 exist, or waiver of any provision be valid, unless granted herein or
239 expressed in writing added hereto. No provision, stipulation or
240 forfeiture shall be held to be waived by any requirement or proceeding
241 on the part of this Company relating to appraisal or to any
242 examination provided for herein.

243 Cancellation of policy. This policy shall be cancelled at any time at
244 the request of the insured, in which case this Company shall, upon
245 demand and surrender of this policy, refund the excess of paid
246 premium above the customary short rates for the expired time. This
247 policy may be cancelled at any time by this Company by giving to the
248 insured and any third party designated pursuant to section 38a-323a, a
249 thirty days' written notice of cancellation accompanied by the reason
250 therefor with or without tender of the excess of paid premium above

251 the pro rata premium for the expired time, which excess, if not
252 tendered, shall be refunded on demand. Notice of cancellation shall
253 state that said excess premium (if not tendered) will be refunded on
254 demand. Where cancellation is for nonpayment of premium at least ten
255 days' written notice of cancellation accompanied by the reason therefor
256 shall be given.

257 Mortgagee interests and obligations. If loss hereunder is made
258 payable, in whole or in part, to a designated mortgagee not named
259 herein as the insured, such interest in this policy may be cancelled by
260 giving to such mortgagee a ten days' written notice of cancellation.

261 If the insured fails to render proof of loss such mortgagee, upon
262 notice, shall render proof of loss in the form herein specified within
263 sixty (60) days thereafter and shall be subject to the provisions hereof
264 relating to appraisal and time of payment and of bringing suit. If this
265 Company shall claim that no liability existed as the mortgagor or
266 owner, it shall, to the extent of payment of loss to the mortgagee, be
267 subrogated to all the mortgagee's rights of recovery, but without
268 impairing mortgagee's right to sue; or it may pay off the mortgage debt
269 and require an assignment thereof and of the mortgage. Other
270 provisions relating to the interests and obligations of such mortgagee
271 may be added hereto by agreement in writing.

272 Pro rata liability. This Company shall not be liable for a greater
273 proportion of any loss than the amount hereby insured shall bear to
274 the whole insurance covering the property against the peril involved,
275 whether collectible or not.

276 Requirements in case loss occurs. The insured shall give immediate
277 written notice to this Company of any loss, protect the property from
278 further damage, forthwith separate the damaged and undamaged
279 personal property, put it in the best possible order, furnish a complete
280 inventory of the destroyed, damaged and undamaged property,
281 showing in detail quantities, costs, actual cash value and amount of
282 loss claims; [AND WITHIN SIXTY DAYS AFTER THE LOSS, UNLESS
283 SUCH TIME IS EXTENDED IN WRITING BY THIS COMPANY, THE

284 INSURED SHALL RENDER TO THIS COMPANY A PROOF OF
285 LOSS] and within sixty days after the loss, unless such time is
286 extended in writing by this company, the insured shall render to this
287 company a proof of loss, signed and sworn to by the insured, stating
288 the knowledge and belief of the insured as to the following: The time
289 and origin of the loss, the interest of the insured and of all others in the
290 property, the actual cash value of each item thereof and the amount of
291 loss thereto, all encumbrances thereon, all other contracts of insurance,
292 whether valid or not, covering any of said property, any changes in the
293 title, use, occupation, location, possession or exposures of said
294 property since the issuing of this policy, by whom and for what
295 purpose any building herein described and the several parts thereof
296 were occupied at the time of loss and whether or not it then stood on
297 leased ground, and shall furnish a copy of all the descriptions and
298 schedules in all policies and, if required, verified plans and
299 specification of any building, fixtures or machinery destroyed or
300 damaged. The insured, as often as may be reasonably required, shall
301 exhibit to any person designated by this Company all that remains of
302 any property herein described, and submit to examinations under oath
303 by any person named by this Company, and subscribe the same; and,
304 as often as may be reasonably required, shall produce for examination
305 all books of account, bills, invoices and other vouchers, or certified
306 copies thereof if originals be lost, at such reasonable time and place as
307 may be designated by this Company or its representative, and shall
308 permit extracts and copies thereof to be made.

309 Appraisal. In case the insured and this Company shall fail to agree
310 as to the actual cash value or the amount of loss, then, on the written
311 demand of either, each shall select a competent and disinterested
312 appraiser and notify the other of the appraiser selected within twenty
313 days of such demand. The appraisers shall first select a competent and
314 disinterested umpire; and failing for fifteen days to agree upon such
315 umpire, then, on request of the insured or this Company, such umpire
316 shall be selected by a judge of a court of record in this state in which
317 the property covered is located. The appraisers shall then appraise the
318 loss, stating separately actual cash value and loss to each item; and,

319 failing to agree, shall submit their differences, only, to the umpire. An
320 award in writing, so itemized, of any two when filed with this
321 Company shall determine the amount of actual cash value and loss.
322 Each appraiser shall be paid by the party selecting him and the
323 expenses of appraisal and umpire shall be paid by the parties equally.

324 Company's options. It shall be optional with this Company to take
325 all, or any part, of the property at the agreed or appraised value, and
326 also to repair, rebuild or replace the property destroyed or damaged
327 with other of like kind and quality within a reasonable time, on giving
328 notice of its intention so to do within thirty days after the receipt of the
329 proof of loss herein required.

330 Abandonment. There can be no abandonment to this Company of
331 any property.

332 When loss payable. The amount of loss for which this Company
333 may be liable shall be payable thirty days after proof of loss, as herein
334 provided, is received by this Company and ascertainment of the loss is
335 made either by agreement between the insured and this Company
336 expressed in writing or by the filing with this Company of an award as
337 herein provided. This Company and the insured may agree in writing
338 to a partial payment of the amount of loss as an advance payment.
339 Any advance payment shall be credited against the total amount of
340 loss due to the insured. An advance payment shall not affect the
341 requirement of this Company to pay the total amount of loss not later
342 than thirty days after proof of loss.

343 Suit. No suit or action on this policy for the recovery of any claim
344 shall be sustainable in any court of law or equity unless all the
345 requirements of this policy shall have been complied with, and unless
346 commenced within eighteen months next after inception of the loss.

347 Subrogation. This Company may require from the insured an
348 assignment of all right of recovery against any party for loss to the
349 extent that payment therefor is made by this Company.

350 Sec. 9. Section 38a-307a of the 2010 supplement to the general
351 statutes is repealed and the following is substituted in lieu thereof
352 (*Effective from passage*):

353 From July 1, 2004, until the expiration of the Terrorism Insurance
354 Program established in the federal Terrorism Risk Insurance Act of
355 2002, P.L. 107-297, as amended from time to time, [for] (1) for any
356 master policy that is required to be purchased by a condominium
357 association pursuant to section 47-83 or by a unit owners' association
358 pursuant to section 47-255, the standard form of fire insurance policy
359 set forth in section 38a-307, as amended by this act, shall not exclude
360 coverage for loss by fire or other perils insured against in the policy
361 caused, directly or indirectly, by terrorism, as defined by the Insurance
362 Commissioner; and (2) for any other commercial risk insurance policy,
363 the standard form of fire insurance policy set forth in section 38a-307,
364 as amended by this act, may provide that the company shall not be
365 liable for loss by fire or other perils insured against in the policy
366 caused, directly or indirectly, by terrorism, as defined by the Insurance
367 Commissioner, provided the premiums charged for such policy shall
368 reflect any savings projected from the exclusion of such perils.

369 Sec. 10. Subdivision (2) of subsection (a) of section 38a-336 of the
370 general statutes is repealed and the following is substituted in lieu
371 thereof (*Effective from passage*):

372 (2) Notwithstanding any provision of this section, [to the contrary,]
373 each automobile liability insurance policy issued or renewed on and
374 after January 1, 1994, shall provide uninsured and underinsured
375 motorist coverage with limits for bodily injury and death equal to
376 those purchased to protect against loss resulting from the liability
377 imposed by law unless any named insured requests in writing a lesser
378 amount, but not less than the limits specified in subsection (a) of
379 section 14-112. Such written request shall apply to all subsequent
380 renewals of coverage and to all policies or endorsements [which] that
381 extend, change, supersede or replace an existing policy issued to the
382 named insured, unless changed in writing by any named insured. No

383 such written request for a lesser amount shall be effective unless any
384 named insured has signed an informed consent form [which] that shall
385 contain: (A) An explanation of uninsured and underinsured motorist
386 insurance approved by the commissioner; (B) a list of uninsured and
387 underinsured motorist coverage options available from the insurer;
388 and (C) the premium cost for each of the coverage options available
389 from the insurer. Such informed consent form shall contain a heading
390 in twelve-point type and shall state: "WHEN YOU SIGN THIS FORM,
391 YOU ARE CHOOSING A REDUCED PREMIUM, BUT YOU ARE
392 ALSO CHOOSING NOT TO PURCHASE CERTAIN VALUABLE
393 COVERAGE WHICH PROTECTS YOU AND YOUR FAMILY. IF YOU
394 ARE UNCERTAIN ABOUT HOW THIS DECISION WILL AFFECT
395 YOU, YOU SHOULD GET ADVICE FROM YOUR INSURANCE
396 AGENT OR ANOTHER QUALIFIED ADVISER."

397 Sec. 11. Section 38a-352 of the general statutes is repealed and the
398 following is substituted in lieu thereof (*Effective from passage*):

399 All claims paid by an insurer, a holding company of an insurer or a
400 wholly owned subsidiary of an insurer for any loss to a motor
401 [vehicles] vehicle or any claim for damages to a motor [vehicles]
402 vehicle, shall be paid to the claimant by check, electronic transfer to the
403 claimant or other means that provide the claimant immediate access to
404 the funds.

405 Sec. 12. Subsection (a) of section 38a-433 of the general statutes is
406 repealed and the following is substituted in lieu thereof (*Effective from*
407 *passage*):

408 (a) A domestic life insurance company, including for the purposes
409 of this section all domestic fraternal benefit societies which operate on
410 a legal reserve basis, may establish one or more separate accounts and
411 may allocate thereto amounts, including without limitation proceeds
412 applied under optional modes of settlement or under dividend
413 options, to provide for life insurance or life or period-certain annuities,
414 and benefits incidental thereto, payable in fixed or variable amounts or
415 both, or to accumulate funds which are paid to or held by such

416 company pursuant to section 38a-459, subject to the following: [(i)] (1)
417 The income, gains and losses, realized or unrealized, from assets
418 allocated to a separate account shall be credited to or charged against
419 the account, without regard to other income, gains or losses of the
420 company; [(ii)] (2) except as may be provided with respect to reserves
421 for guaranteed benefits and funds referred to in subdivision [(iii)
422 hereof] (3) of this subsection, amounts allocated to any separate
423 account and accumulations thereon may be invested and reinvested in
424 any class of loans and investments, and such loans and investments
425 shall not be included in applying the limitations provided in sections
426 38a-102 to 38a-102h, inclusive, as amended by this act; [(iii)] (3) except
427 with the approval of the commissioner and under such conditions as to
428 investments and other matters as he may prescribe, which shall
429 recognize the guaranteed nature of the benefits provided, reserves for
430 [(1)] (A) benefits guaranteed as to dollar amount and duration, and
431 [(2)] (B) funds guaranteed as to principal amount or stated rate of
432 interest shall not be maintained in a separate account; [(iv)] (4) unless
433 otherwise approved by the commissioner, assets allocated to a separate
434 account shall be valued at their market value on the date of valuation,
435 or if there is no readily available market, then as provided under the
436 terms of the contract or the rules or other written agreement applicable
437 to such separate account, provided, that unless otherwise approved by
438 the commissioner, the portion, if any, of the assets of such separate
439 account equal to the company's reserve liability with regard to the
440 guaranteed benefits and funds referred to in subdivision [(iii) hereof]
441 (3) of this subsection, shall be valued in accordance with the rules
442 otherwise applicable to the company's assets; [(v)] (5) amounts
443 allocated to a separate account in the exercise of the power granted by
444 this section shall be owned by the company, and the company shall not
445 be, nor hold itself out to be, a trustee with respect to such amounts. If,
446 and to the extent so provided under the applicable contracts, that
447 portion of the assets of any such separate account equal to the reserves
448 and other contract liabilities with respect to such account shall not be
449 chargeable with liabilities arising out of any other business the
450 company may conduct; [(vi)] (6) no sale, exchange or other transfer of

451 assets may be made by a company between any of its separate
452 accounts or between any other investment account and one or more of
453 its separate accounts unless, in case of a transfer into a separate
454 account, such transfer is made solely to establish the account or to
455 support the operation of the contracts with respect to the separate
456 account to which the transfer is made, and unless such transfer,
457 whether into or from a separate account, is made [(1)] (A) by a transfer
458 of cash, or [(2)] (B) by a transfer of securities having a readily
459 determinable market value, provided that such transfer of securities is
460 approved by the commissioner. The commissioner may approve other
461 transfers among such accounts if, in his opinion, such transfers would
462 not be inequitable; [(vii)] (Z) to the extent such company deems it
463 necessary to comply with any applicable federal or state laws, such
464 company, with respect to any separate account, including without
465 limitation any separate account which is a management investment
466 account or a unit investment trust, may provide for persons having an
467 interest therein appropriate voting and other rights and special
468 procedures for the conduct or the business of such account, including
469 without limitation special rights and procedures relating to investment
470 policy, investment advisory services, selection of independent public
471 accountants, and the selection of a committee, the members of which
472 need not be otherwise affiliated with such company, to manage the
473 business of such account. The provisions of this subsection shall apply
474 notwithstanding any inconsistent provision in the charter of any such
475 domestic life insurance company or in the general statutes.

476 Sec. 13. Subsection (e) of section 38a-439 of the general statutes is
477 repealed and the following is substituted in lieu thereof (*Effective from*
478 *passage*):

479 (e) The provisions of this subsection shall apply to all policies issued
480 on or after the compliance date established by subdivision (11) of this
481 subsection. (1) Except as provided in subdivision (7) of this subsection,
482 the adjusted premiums for any policy shall be calculated on an annual
483 basis and shall be such uniform percentage of the respective premiums
484 specified in the policy for each policy year, excluding amounts payable

485 as extra premiums to cover impairments or special hazards and also
486 excluding any uniform annual contract charge or policy fee specified
487 in the policy in a statement of the method used in calculating the cash
488 surrender values and paid-up nonforfeiture benefits, that the present
489 value, at the date of issue of the policy, of all adjusted premiums shall
490 be equal to the sum of: (A) The then present value of the future
491 guaranteed benefits provided for by the policy; (B) one per cent of
492 either the amount of insurance, if the insurance be uniform in amount,
493 or the average amount of insurance at the beginning of each of the first
494 ten policy years; and (C) one hundred twenty-five per cent of the
495 nonforfeiture net level premium as hereinafter defined, provided that
496 in applying the percentage specified in this subparagraph, [(C),] no
497 nonforfeiture net level premium shall be deemed to exceed four per
498 cent of either the amount of insurance, if the insurance be uniform in
499 amount, or the average amount of insurance at the beginning of each
500 of the first ten policy years. The date of issue of a policy for the
501 purpose of this subsection shall be the date as of which the rated age of
502 the insured is determined; (2) the nonforfeiture net level premium
503 shall be equal to the present value, at the date of issue of the policy, of
504 the guaranteed benefits divided by the present value, at such date of
505 issue, of an annuity of one per annum payable on the date of issue of
506 the policy and on each anniversary of such policy on which a premium
507 becomes due; (3) in the case of policies [which] that, on a basis
508 guaranteed in the policy, provide for unscheduled changes in benefits
509 or premiums, or [which] that provide an option for changes in benefits
510 or premiums other than a change to a new policy, the adjusted
511 premiums and present values shall initially be calculated on the
512 assumption that future benefits and premiums do not change from
513 those stipulated at the date of issue of the policy. At the time of any
514 such change in the benefits or premiums the future adjusted
515 premiums, nonforfeiture net level premiums and present values shall
516 be recalculated on the assumption that future benefits and premiums
517 do not change from those stipulated by the policy immediately after
518 the change; (4) except as otherwise provided in subdivision (7) of this
519 subsection, the recalculated future adjusted premiums for any such

520 policy shall be the uniform percentage of the respective future
521 premiums specified in the policy for each policy year, excluding
522 amounts payable as extra premiums to cover impairments and special
523 hazards, and also excluding any uniform annual contract charge or
524 policy fee specified in the policy in a statement of the method used in
525 calculating the cash surrender values and paid-up nonforfeiture
526 benefits, that the present value, at the time of change to the newly
527 defined benefits or premiums, of all such future adjusted premiums
528 shall be equal to the excess of (A) the sum of: (i) The then present value
529 of the future guaranteed benefits provided for by the policy and (ii) the
530 additional expense allowance, if any, over (B) the then cash surrender
531 value, if any, or present value of any paid-up nonforfeiture benefit
532 under the policy; (5) the additional expense allowance, at the time of
533 the change to the newly defined benefits or premiums, shall be the
534 sum of (A) one per cent of the excess, if positive, of the average
535 amount of insurance at the beginning of each of the first ten policy
536 years subsequent to the change over the average amount of insurance
537 prior to the change at the beginning of each of the first ten policy years
538 subsequent to the time of the most recent previous change, or, if there
539 has been no previous change, the date of issue of the policy; and (B)
540 one hundred twenty-five per cent of the increase, if positive, in the
541 nonforfeiture net level premium; (6) the recalculated nonforfeiture net
542 level premium shall be equal to the amount obtained by dividing (A)
543 by (B) where (A) equals the sum of (i) the nonforfeiture net level
544 premium applicable prior to the change, multiplied by the present
545 value of an annuity of one per annum payable on each anniversary of
546 the policy on or subsequent to the date of change on which a premium
547 would have become due had the change not occurred, and (ii) the
548 present value of the increase in future guaranteed benefits provided
549 for by the policy, and (B) equals the present value of an annuity of one
550 per annum payable on each anniversary of the policy on or subsequent
551 to the date of change on which a premium becomes due; (7)
552 notwithstanding any other provisions of this subsection, in the case of
553 a policy issued on a substandard basis [which] that provides reduced
554 graded amounts of insurance so that, in each policy year, such policy

555 has the same tabular mortality cost as an otherwise similar policy
556 issued on the standard basis [which] that provides higher uniform
557 amounts of insurance, adjusted premiums and present values for such
558 substandard policy may be calculated as if it were issued to provide
559 such higher uniform amounts of insurance on the standard basis; (8)
560 all adjusted premiums and present values referred to in this section
561 shall be calculated: (A) (i) For all policies of ordinary insurance on the
562 basis of the Commissioners' 1980 Standard Ordinary Mortality Table
563 or at the election of the company, for any one or more specified plans
564 of life insurance, on the basis of the Commissioners' 1980 Standard
565 Ordinary Mortality Table with ten-year select mortality factors, or (ii)
566 [On] on or after January 1, 2005, until January 1, 2009, at the election of
567 the company for any one or more specified plans of life insurance
568 issued on or after January 1, 2004, on the basis of the Commissioners'
569 2001 Standard Ordinary Mortality Table, except that with respect to
570 such plans issued before April 1, 2005, such mortality table shall be
571 used solely for the basis of valuation and nonforfeiture and shall not be
572 used to increase the previously agreed required premium; or (iii) [For]
573 for all policies issued on or after January 1, 2009, on the basis of the
574 Commissioners' 2001 Standard Ordinary Mortality Table; (B) for all
575 policies of industrial insurance, on the basis of the Commissioners'
576 1961 Standard Industrial Mortality Table; (C) for all policies issued in a
577 particular calendar year, on the basis of a rate of interest not exceeding
578 the nonforfeiture interest rate as defined in this subsection, for policies
579 issued in that calendar year, provided, that: (i) At the option of the
580 company, calculations for all policies issued in a particular calendar
581 year may be made on the basis of a rate of interest not exceeding the
582 nonforfeiture interest rate, as defined in this subsection, for policies
583 issued in the immediately preceding calendar year; (ii) under any paid-
584 up nonforfeiture benefit, including any paid-up dividend additions,
585 any cash surrender value available, whether or not required by
586 subsection (a) of this section, shall be calculated on the basis of the
587 mortality table and rate of interest used in determining the amount of
588 such paid-up nonforfeiture benefit and paid-up dividend additions, if
589 any; (iii) a company may calculate the amount of any guaranteed paid-

590 up nonforfeiture benefit including any paid-up additions under the
591 policy on the basis of an interest rate no lower than that specified in
592 the policy for calculating cash surrender values; (iv) in calculating the
593 present value of any paid-up term insurance with accompanying pure
594 endowment, if any, offered as a nonforfeiture benefit, the rates of
595 mortality assumed may be not more than those shown in the
596 Commissioners' 1980 Extended Term Insurance Table for policies of
597 ordinary insurance and not more than the Commissioners' 1961
598 Industrial Extended Term Insurance Table for policies of industrial
599 insurance; (v) for insurance issued on a substandard basis, the
600 calculation of any such adjusted premiums and present values may be
601 based on appropriate modifications of the aforementioned tables; (vi)
602 any ordinary mortality tables, adopted after 1980 by the National
603 Association of Insurance Commissioners that are approved by
604 regulations adopted by the commissioner, in accordance with the
605 provisions of chapter 54, for use in determining the minimum
606 nonforfeiture standard may be substituted for the Commissioners'
607 1980 Standard Ordinary Mortality Table with or without ten-year
608 select mortality factors or the Commissioners' 1980 Extended Term
609 Insurance Table; (vii) any industrial mortality tables, adopted after
610 1980 by the National Association of Insurance Commissioners that are
611 approved by regulations adopted by the commissioner, in accordance
612 with the provisions of chapter 54, ~~[by the commissioner]~~ for use in
613 determining the minimum nonforfeiture standard may be substituted
614 for the Commissioners' 1961 Standard Industrial Mortality Table or the
615 Commissioners' 1961 Industrial Extended Term Insurance Table; (9)
616 the nonforfeiture interest rate per annum for any policy issued in a
617 particular calendar year shall be equal to one hundred twenty-five per
618 cent of the calendar year statutory valuation interest rate for such
619 policy as defined in the standard valuation law, rounded to the nearest
620 one quarter of one per cent; (10) notwithstanding any provision of the
621 general statutes, ~~[to the contrary,]~~ any refiling of nonforfeiture values
622 or their methods of computation for any previously approved policy
623 form [which] that involves only a change in the interest rate or
624 mortality table used to compute nonforfeiture values shall not require

625 refiling of any other provisions of [that] such policy form; (11) on or
626 after October 1, 1981, but prior to January 1, 1989, any company may
627 file with the commissioner a written notice of its election to comply
628 with the provisions of this subsection on or after a specified date and
629 the provisions of this subsection shall apply to such company on or
630 after such specified date, except that on or after January 1, 2005, but
631 prior to January 1, 2009, any company may file with the commissioner
632 a written notice of its election to comply with the provisions of this
633 subsection on or after a specified date with respect to the
634 Commissioners' 2001 Standard Ordinary Mortality Table and the
635 provisions of this subsection shall apply to such company. The
636 provisions of this subsection shall apply to policies issued by any
637 company on or after January 1, 1989, except that the provisions of this
638 subsection with respect to the Commissioners' 2001 Standard Ordinary
639 Mortality Table shall apply to policies issued by any company on or
640 after January 1, 2009.

641 Sec. 14. Section 38a-465a of the 2010 supplement to the general
642 statutes is repealed and the following is substituted in lieu thereof
643 (*Effective from passage*):

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

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

651 (c) A life insurance producer, who has been duly licensed as a
652 resident insurance producer with a life line of authority in this state or
653 in such producer's home state for not less than one year and is licensed
654 as a nonresident producer pursuant to section 38a-702g, shall be
655 deemed to meet the licensing requirements of this section and shall be
656 permitted to operate as a broker.

657 (d) Not later than thirty days after the first day of operating as a
658 broker, a life insurance producer shall notify the commissioner that
659 such producer is acting as a broker on a form prescribed by the
660 commissioner, and shall pay a filing fee as specified in section 38a-11.
661 Such notification shall include an acknowledgement by the life
662 insurance producer that such producer shall operate as a broker in
663 accordance with this part.

664 (e) The insurer that issued the policy that is the subject of a life
665 settlement contract shall not be responsible for any act or omission of a
666 broker, provider or purchaser arising out of or in connection with the
667 life settlement transaction, unless the insurer receives compensation
668 for the placement of a life settlement contract from the broker,
669 provider or purchaser in connection with such life settlement contract.

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

676 (g) Any license issued for a provider or broker shall be in force only
677 until the last day of March in each year, but may be renewed by the
678 commissioner without formality other than proper application. The
679 fees for such licenses shall be assessed annually, as provided in section
680 38a-11. If such provider or broker fails to timely pay the renewal fee,
681 such license shall be automatically revoked if the license fee is not
682 received by the commissioner not later than the fifth day after the
683 commissioner sends, by first class mail, a written notice of nonrenewal
684 to the principal office of the provider or broker, provided such notice
685 shall only be mailed after said last day of March.

686 [(h) The term of a provider license shall be equal to that of a
687 domestic stock life insurance company and the term of a broker license
688 shall be equal to that of an insurance producer license. Licenses
689 requiring periodic renewal shall be renewed on their anniversary date

690 upon payment of the renewal fee, as specified in subsection (b) of this
691 section. Failure to pay the fees on or before the renewal date shall
692 result in expiration of the license.]

693 [(i)] (h) Upon the filing of an application and full payment of the
694 license fee, the commissioner shall investigate the applicant and shall
695 issue a license if the commissioner determines that:

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

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

700 (3) The applicant has a good business reputation and adequate
701 experience, training or education so as to be qualified in the business
702 for which the license is applied;

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

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

711 (A) A description of the procedures for detecting and investigating
712 possible fraudulent acts and procedures for resolving material
713 inconsistencies between medical records and insurance applications;

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

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

718 (D) A written description or chart outlining the arrangement of the

719 antifraud personnel responsible for the investigation and reporting of
720 possible fraudulent insurance acts and investigating unresolved
721 material inconsistencies between medical records and insurance
722 applications.

723 [(j)] (i) The applicant shall provide to the commissioner such
724 information as the commissioner may require, on forms approved by
725 the commissioner. The commissioner may, at any time, require the
726 applicant to fully disclose the identity of its stockholders, except
727 stockholders owning less than ten per cent of the shares of an applicant
728 whose shares are publicly traded, partners, officers and employees,
729 and the commissioner may deny any application for a license if the
730 commissioner determines that any partner, officer, employee or
731 stockholder thereof who may materially influence the applicant's
732 conduct fails to meet any of the standards set forth in sections 38a-465
733 to 38a-465q, inclusive.

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

739 [(l)] (k) The commissioner shall not issue any license to any
740 nonresident applicant unless a written designation of an agent for
741 service of process is filed and maintained with the commissioner or
742 unless the applicant has filed with the commissioner the applicant's
743 written irrevocable consent that any action against the applicant may
744 be commenced against the applicant by service of process on the
745 commissioner.

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

749 [(n)] (m) A provider shall not use any person to perform the
750 functions of a broker, as defined in this part, unless such person holds

751 a current, valid license as a broker and as provided in this section.

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

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

760 ~~[(q)]~~ ~~(p)~~ An individual licensed as a broker shall complete, on a
761 biennial basis, fifteen hours of training related to life settlements and
762 life settlement transactions, except that a life insurance producer
763 operating as a broker pursuant to this section shall not be subject to the
764 requirements of this subsection. Any person failing to meet the
765 requirements of this subsection shall be subject to the penalties
766 imposed by the commissioner.

767 Sec. 15. Subsection (a) of section 38a-465c of the 2010 supplement to
768 the general statutes is repealed and the following is substituted in lieu
769 thereof (*Effective from passage*):

770 (a) No person shall use any form of life settlement contract or
771 disclosure statement in this state unless such form has been filed with
772 and approved by the commissioner. The commissioner shall
773 disapprove a life settlement contract form or disclosure statement form
774 if the commissioner finds any provision in ~~[said]~~ such form is
775 unreasonable, contrary to the interests of the public, fails to comply
776 with the provisions of sections 38a-465f, 38a-465g, as amended by this
777 act, and 38a-465n and subsection (b) of section 38a-465k, or is
778 otherwise misleading or unfair to the owner. The commissioner may
779 require the submission of advertising materials.

780 Sec. 16. Section 38a-465g of the general statutes is repealed and the
781 following is substituted in lieu thereof (*Effective from passage*):

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

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

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

793 (b) The insurer shall respond to a request for verification of
794 coverage submitted by a provider, broker or life insurance producer on
795 a form approved by the commissioner not later than thirty calendar
796 days after the date the request was received. The insurer shall
797 complete and issue the verification of coverage or indicate in which
798 respects it is unable to respond. In its response, the insurer shall
799 indicate whether, based on the medical evidence and documents
800 provided, the insurer intends to pursue an investigation regarding the
801 validity of the policy.

802 (c) Prior to or at the time of execution of the settlement contract, the
803 provider shall obtain a witnessed document in which the owner
804 consents to the settlement contract, represents that the owner has a full
805 and complete understanding of the settlement contract, that the owner
806 has a full and complete understanding of the benefits of the policy,
807 acknowledges that the owner is entering into the settlement contract
808 freely and voluntarily and, for persons with a terminal or chronic
809 illness or condition, acknowledges that the insured has a terminal or
810 chronic illness or condition and that the terminal or chronic illness or
811 condition was diagnosed after the life insurance policy was issued.

812 (d) If a broker or life insurance producer performs any of the
813 activities required of the provider under this section, the provider shall

814 be deemed to have fulfilled the requirements of this section.

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

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

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

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

832 [(i)] (h) Each life settlement contract entered into in this state shall
833 provide that the owner may rescind the contract not later than fifteen
834 days from the date it is executed by all parties thereto. Such rescission
835 exercised by the owner shall be effective only if both notice of
836 rescission is given to the provider and the owner repays all proceeds
837 and any premiums, loans and loan interest paid by the provider within
838 the rescission period. A failure to provide written notice of the right of
839 rescission shall toll the period of such right until thirty days after the
840 written notice of the right of rescission has been given. If the insured
841 dies during the rescission period, the contract shall be deemed to have
842 been rescinded, subject to repayment by the owner or the owner's
843 estate of all proceeds and any premiums, loans and loan interest to the
844 provider.

845 [(j)] (i) Not later than three business days after the date the provider
846 receives the documents from the owner to effect the transfer of the
847 insurance policy, the provider shall pay or transfer the proceeds of the
848 settlement into an escrow or trust account managed by a trustee or
849 escrow agent in a state or federally-chartered financial institution
850 whose deposits are insured by the Federal Deposit Insurance
851 Corporation. Not later than three business days after receiving
852 acknowledgment of the transfer of the insurance policy from the issuer
853 of the policy, said trustee or escrow agent shall pay the settlement
854 proceeds to the owner.

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

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

866 [(m)] (l) Each broker shall disclose to the owner anything of value
867 paid or given to such broker in connection with a life settlement
868 contract concerning the owner.

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

876 (1) The policy was issued upon the owner's exercise of conversion

877 rights arising out of a group or individual policy, provided the total of
878 the time covered under the conversion policy plus the time covered
879 under the prior policy is not less than twenty-four months. The time
880 covered under a group policy must be calculated without regard to a
881 change in insurance carriers, provided the coverage has been
882 continuous and under the same group sponsorship; or

883 (2) The owner submits independent evidence to the provider that
884 one or more of the following conditions have been met within said
885 two-year period: (A) The owner or insured is terminally ill or
886 chronically ill; (B) the owner or insured disposes of the owner or
887 insured's ownership interests in a closely held corporation, pursuant to
888 the terms of a buyout or other similar agreement in effect at the time
889 the insurance policy was initially issued; (C) the owner's spouse dies;
890 (D) the owner divorces his or her spouse; (E) the owner retires from
891 full-time employment; (F) the owner becomes physically or mentally
892 disabled and a physician determines that the disability prevents the
893 owner from maintaining full-time employment; or (G) a final order,
894 judgment or decree is entered by a court of competent jurisdiction on
895 the application of a creditor of the owner, adjudicating the owner
896 bankrupt or insolvent, or approving a petition seeking reorganization
897 of the owner or appointing a receiver, trustee or liquidator to all or a
898 substantial part of the owner's assets.

899 [(o)] (n) Copies of the independent evidence required by
900 subdivision (2) of subsection [(n)] (m) of this section shall be submitted
901 to the insurer when the provider submits a request to the insurer for
902 verification of coverage. The copies shall be accompanied by a letter of
903 attestation from the provider that the copies are true and correct copies
904 of the documents received by the provider. Nothing in this section
905 shall prohibit an insurer from exercising its right to contest the validity
906 of any policy.

907 [(p)] (o) If, at the time the provider submits a request to the insurer
908 to effect the transfer of the policy to the provider, the provider submits
909 a copy of independent evidence of subparagraph (A) of subdivision (2)

910 of subsection [(n)] (m) of this section, such copy shall be deemed to
911 establish that the settlement contract satisfies the requirements of this
912 section.

913 Sec. 17. Subdivision (1) of subsection (a) of section 38a-478c of the
914 2010 supplement to the general statutes is repealed and the following
915 is substituted in lieu thereof (*Effective from passage*):

916 (1) A report on its quality assurance plan that includes, but is not
917 limited to, information on complaints related to providers and quality
918 of care, on decisions related to patient requests for coverage and on
919 prior authorization statistics. Statistical information shall be submitted
920 in a manner permitting comparison across plans and shall include, but
921 not be limited to: (A) The ratio of the number of complaints received to
922 the number of enrollees; (B) a summary of the complaints received
923 related to providers and delivery of care or services and the action
924 taken on the complaint; (C) the ratio of the number of prior
925 authorizations denied to the number of prior authorizations requested;
926 (D) the number of utilization review determinations made by or on
927 behalf of a managed care organization not to certify an admission,
928 service, procedure or extension of stay, and the denials upheld and
929 reversed on appeal within the managed care organization's utilization
930 review procedure; (E) the percentage of those employers or groups
931 that renew their contracts within the previous twelve months; and (F)
932 notwithstanding the provisions of this subsection, on or before July [1,
933 1998, and annually thereafter] first of each year, all data required by
934 the National Committee for Quality Assurance (NCQA) for its Health
935 Plan Employer Data and Information Set (HEDIS). If an organization
936 does not provide information for the National Committee for Quality
937 Assurance for its Health Plan Employer Data and Information Set, then
938 it shall provide such other equivalent data as the commissioner may
939 require by regulations adopted in accordance with the provisions of
940 chapter 54. The commissioner shall find that the requirements of this
941 subdivision have been met if the managed care plan has received a
942 one-year or higher level of accreditation by the National Committee for
943 Quality Assurance and has submitted the Health Plan Employee Data

944 Information Set data required by subparagraph (F) of this subdivision.

945 Sec. 18. Subsection (b) of section 38a-479rr of the general statutes is
946 repealed and the following is substituted in lieu thereof (*Effective from*
947 *passage*):

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

952 (2) Any change made to the list of authorized marketers, specified in
953 subparagraph (M) of subdivision (2) of subsection (a) of this section,
954 shall be electronically filed with the commissioner. If such change is to
955 add a marketer to a medical discount plan organization's list of
956 authorized marketers, such change shall be electronically filed by such
957 organization prior to the marketer doing business in the state for such
958 organization.

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

962 Sec. 19. Subsection (b) of section 38a-481 of the general statutes is
963 repealed and the following is substituted in lieu thereof (*Effective from*
964 *passage*):

965 (b) No rate filed under the provisions of subsection (a) of this
966 section shall be effective until the expiration of thirty days after it has
967 been filed or unless sooner approved by the commissioner in
968 accordance with regulations adopted pursuant to this subsection. The
969 commissioner shall adopt regulations, in accordance with chapter 54,
970 to prescribe standards to [insure] ensure that such rates shall not be
971 excessive, inadequate or unfairly discriminatory. The commissioner
972 may disapprove such rate within thirty days after it has been filed if it
973 fails to comply with such standards, except that no rate filed under the
974 provisions of subsection (a) of this section for any Medicare

975 supplement policy shall be effective unless approved in accordance
976 with section 38a-474.

977 Sec. 20. Subdivision (6) of subsection (b) of section 38a-483 of the
978 general statutes is repealed and the following is substituted in lieu
979 thereof (*Effective from passage*):

980 (6) A provision as follows: "RELATION OF EARNINGS TO
981 INSURANCE: If the total monthly amount of loss of time benefits
982 promised for the same loss under all valid loss of time coverage upon
983 the insured, whether payable on a weekly or monthly basis, shall
984 exceed the monthly earnings of the insured at the time disability
985 commenced or his average monthly earnings for the period of two
986 years immediately preceding a disability for which claim is made,
987 whichever is the greater, the insurer will be liable only for such
988 proportionate amount of such benefits under this policy as the amount
989 of such monthly earnings or such average monthly earnings of the
990 insured bears to the total amount of monthly benefits for the same loss
991 under all such coverage upon the insured at the time such disability
992 commences and for the return of such part of the premiums paid
993 during such two years as shall exceed the pro-rata amount of the
994 premiums for the benefits actually paid hereunder; but this shall not
995 operate to reduce the total monthly amount of benefits payable under
996 all such coverage upon the insured below the sum of two hundred
997 dollars or the sum of the monthly benefits specified in such coverages,
998 whichever is the lesser, nor shall it operate to reduce benefits other
999 than those payable for loss of time." The foregoing policy provision
1000 may be inserted only in a policy which the insured has the right to
1001 continue in force subject to its terms by the timely payment of
1002 premiums (1) until at least age fifty, or (2) [] in the case of a policy
1003 issued after age forty-four, for at least five years from its date of issue.
1004 The insurer may, at its option, include in this provision a definition of
1005 "valid loss of time coverage", approved as to form by the
1006 commissioner, which definition shall be limited in subject matter to
1007 coverage provided by governmental agencies or by organizations
1008 subject to regulation by insurance law or by insurance authorities of

1009 this or any other state of the United States or any province of Canada,
1010 or to any other coverage the inclusion of which may be approved by
1011 the commissioner or any combination of such coverages. In the
1012 absence of such definition such term shall not include any coverage
1013 provided for such insured pursuant to any compulsory benefit statute,
1014 including any workers' compensation or employer's liability statute, or
1015 benefits provided by union welfare plans or by employer or employee
1016 benefit organizations.

1017 Sec. 21. Section 38a-491a of the general statutes is repealed and the
1018 following is substituted in lieu thereof (*Effective January 1, 2011*):

1019 (a) Each individual health insurance policy providing coverage of
1020 the type specified in subdivisions (1), (2), (4), (11) and (12) of section
1021 38a-469 delivered, issued for delivery, renewed, amended or continued
1022 in this state [on or after January 1, 2000,] shall provide coverage for
1023 general anesthesia, nursing and related hospital services provided in
1024 conjunction with in-patient, outpatient or one-day dental services if the
1025 following conditions are met:

1026 (1) The anesthesia, nursing and related hospital services are deemed
1027 medically necessary by the treating dentist or oral surgeon and the
1028 patient's primary care physician in accordance with the health
1029 insurance policy's requirements for prior authorization of services; and

1030 (2) The patient is either (A) determined by a licensed dentist, in
1031 conjunction with a licensed physician who specializes in primary care,
1032 to have a dental condition of significant dental complexity that it
1033 requires certain dental procedures to be performed in a hospital, or (B)
1034 a person who has a developmental disability, as determined by a
1035 licensed physician who specializes in primary care, that places the
1036 person at serious risk.

1037 (b) The expense of such anesthesia, nursing and related hospital
1038 services shall be deemed a medical expense under such health
1039 insurance policy and shall not be subject to any limits on dental
1040 benefits under such policy.

1041 Sec. 22. Section 38a-492j of the general statutes is repealed and the
1042 following is substituted in lieu thereof (*Effective January 1, 2011*):

1043 Each individual health insurance policy providing coverage of the
1044 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
1045 469 delivered, issued for delivery, renewed, amended or continued in
1046 this state [on or after October 1, 2000,] that provides coverage for
1047 ostomy surgery shall include coverage, up to one thousand dollars
1048 annually, for medically necessary appliances and supplies relating to
1049 an ostomy including, but not limited to, collection devices, irrigation
1050 equipment and supplies, skin barriers and skin protectors. As used in
1051 this section, "ostomy" includes colostomy, ileostomy and urostomy.
1052 Payments under this section shall not be applied to any policy
1053 maximums for durable medical equipment. Nothing in this section
1054 shall be deemed to decrease policy benefits in excess of the limits in
1055 this section.

1056 Sec. 23. Subsection (f) of section 38a-495a of the general statutes is
1057 repealed and the following is substituted in lieu thereof (*Effective from*
1058 *passage*):

1059 (f) Notwithstanding any other provision of law, [to the contrary,] a
1060 Medicare supplement policy or certificate shall not exclude or limit
1061 benefits for losses incurred more than six months from the effective
1062 date of coverage because it involved a preexisting condition. The
1063 policy or certificate shall not define a preexisting condition more
1064 restrictively than a condition for which medical advice was given or
1065 treatment was recommended by or received from a physician within
1066 six months before the effective date of coverage.

1067 Sec. 24. Subsection (a) of section 38a-500 of the general statutes is
1068 repealed and the following is substituted in lieu thereof (*Effective*
1069 *January 1, 2011*):

1070 (a) Notwithstanding any other provision of the general statutes, [to
1071 the contrary,] no individual health insurance policy providing
1072 coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11)

1073 and (12) of section 38a-469 delivered, issued for delivery, amended,
1074 [or] renewed [on or after October 1, 1984,] or continued in this state
1075 may exclude coverage for a bodily injury solely because it was caused
1076 by an accident arising out of and in the course of employment to a
1077 covered individual who is: (1) A sole proprietor or business partner
1078 who is not covered by the provisions of chapter 568 or who accepts the
1079 provisions of chapter 568 pursuant to subdivision (10) of section 31-
1080 275; or (2) an employee of a corporation and who is a corporate officer,
1081 regardless of any election by such individual to be excluded from
1082 coverage under chapter 568 pursuant to subparagraph (B)(v) of
1083 subdivision (9) of section 31-275. [The provisions of this section shall
1084 also apply to all such policies or contracts in this state as of the first
1085 anniversary date of such policy or contract on or after October 1, 1984.]
1086 The payment of benefits pursuant to this section shall be subject to any
1087 policy or contract provisions [which] that apply to a claim not
1088 resulting from bodily injury caused by an accident arising out of and
1089 in the course of employment.

1090 Sec. 25. Section 38a-504 of the general statutes is repealed and the
1091 following is substituted in lieu thereof (*Effective January 1, 2011*):

1092 (a) Each insurance company, hospital service corporation, medical
1093 service corporation, health care center or fraternal benefit society
1094 [which] that delivers, [or] issues for delivery, renews, amends or
1095 continues in this state individual health insurance policies providing
1096 coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and
1097 (12) of section 38a-469, shall provide coverage under such policies for
1098 the surgical removal of tumors and treatment of leukemia, including
1099 outpatient chemotherapy, reconstructive surgery, cost of any
1100 nondental prosthesis including any maxillo-facial prosthesis used to
1101 replace anatomic structures lost during treatment for head and neck
1102 tumors or additional appliances essential for the support of such
1103 prosthesis, outpatient chemotherapy following surgical procedure in
1104 connection with the treatment of tumors, and a wig if prescribed by a
1105 licensed oncologist for a patient who suffers hair loss as a result of
1106 chemotherapy. Such benefits shall be subject to the same terms and

1107 conditions applicable to all other benefits under such policies.

1108 (b) Except as provided in subsection (c) of this section, the coverage
1109 required by subsection (a) of this section shall provide at least a yearly
1110 benefit of five hundred dollars for the surgical removal of tumors, five
1111 hundred dollars for reconstructive surgery, five hundred dollars for
1112 outpatient chemotherapy, three hundred fifty dollars for a wig and
1113 three hundred dollars for a nondental prosthesis, except that for
1114 purposes of the surgical removal of breasts due to tumors the yearly
1115 benefit for prosthesis shall be at least three hundred dollars for each
1116 breast removed.

1117 (c) The coverage required by subsection (a) of this section shall
1118 provide benefits for the reasonable costs of reconstructive surgery on
1119 each breast on which a mastectomy has been performed, and
1120 reconstructive surgery on a nondiseased breast to produce a
1121 symmetrical appearance. Such benefits shall be subject to the same
1122 terms and conditions applicable to all other benefits under such
1123 policies. For the purposes of this subsection, reconstructive surgery
1124 includes, but is not limited to, augmentation mammoplasty, reduction
1125 mammoplasty and mastopexy.

1126 Sec. 26. Subsection (c) of section 38a-511 of the general statutes is
1127 repealed and the following is substituted in lieu thereof (*Effective from*
1128 *passage*):

1129 (c) The provisions of subsections (a) and (b) of this section shall not
1130 apply to a high deductible health plan as that term is used in
1131 subsection (f) of section [38a-520] 38a-493.

1132 Sec. 27. Section 38a-513e of the 2010 supplement to the general
1133 statutes is repealed and the following is substituted in lieu thereof
1134 (*Effective from passage*):

1135 (a) In the event (1) an employer, as defined in section 31-58,
1136 terminates an employee for any reason other than layoff or relocation
1137 or closing of a covered establishment, as defined in section 31-51n, or

1138 (2) an employee voluntarily terminates employment with an employer,
1139 such employer may elect not to pay the premium for such employee
1140 and any such employee's dependents under a group health insurance
1141 policy after the date of such employee's termination. In the event such
1142 employer makes such election, any insurer, health care center, hospital
1143 or medical service corporation or fraternal benefit society that issues
1144 such group health insurance policy shall credit such employer the
1145 amount of any premium paid by such employer with respect to such
1146 policy for such employee and such employee's dependents attributable
1147 to the period after the date of such employee's termination, provided
1148 the employer notifies the insurer, health care center, hospital or
1149 medical service corporation or fraternal benefit society that issued such
1150 policy and the terminated employee not later than seventy-two hours
1151 after the termination. Upon the issuance or renewal of such policy,
1152 such insurer, health care center, hospital or medical service
1153 corporation or fraternal benefit society shall provide such employer
1154 with relevant information related to such employer's election,
1155 including a notice that it is the employer's responsibility to remit to the
1156 terminated employee such employee's portion of the credited
1157 premium. Any such credit shall be applied to the employer's next
1158 month's premium. In the event of nonrenewal of such policy, the
1159 insurer, health care center, hospital or medical service corporation or
1160 fraternal benefit society shall refund such credit to the employer.

1161 (b) Notwithstanding the provisions of subsection (a) of this section,
1162 (1) any contractual agreement entered into through collective
1163 bargaining that requires the employer to pay the premium for an
1164 employee under a group health insurance policy after the date of such
1165 employee's termination shall supersede the provisions of subsection (a)
1166 of this section, and (2) no credit shall be available to an employer for
1167 any employee's and employee's dependents' coverage for the seventy-
1168 two hours immediately following the termination of such employee.

1169 (c) Any right of an employee and his dependents to continuation of
1170 coverage following the relocation or closing of a covered
1171 establishment, as set forth in section 31-51o, shall not be affected by the

1172 provisions of this section.

1173 Sec. 28. Subsection (a) of section 38a-517a of the general statutes is
1174 repealed and the following is substituted in lieu thereof (*Effective*
1175 *January 1, 2011*):

1176 (a) Each group health insurance policy providing coverage of the
1177 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
1178 469 delivered, issued for delivery, renewed, amended or continued in
1179 this state [on or after January 1, 2000,] shall provide coverage for
1180 general anesthesia, nursing and related hospital services provided in
1181 conjunction with in-patient, outpatient or one-day dental services if the
1182 following conditions are met:

1183 (1) The anesthesia, nursing and related hospital services are deemed
1184 medically necessary by the treating dentist or oral surgeon and the
1185 patient's primary care physician in accordance with the health
1186 insurance policy's requirements for prior authorization of services; and

1187 (2) The patient is either (A) determined by a licensed dentist, in
1188 conjunction with a licensed physician who specializes in primary care,
1189 to have a dental condition of significant dental complexity that it
1190 requires certain dental procedures to be performed in a hospital, or (B)
1191 a person who has a developmental disability, as determined by a
1192 licensed physician who specializes in primary care, that places the
1193 person at serious risk.

1194 Sec. 29. Section 38a-518j of the general statutes is repealed and the
1195 following is substituted in lieu thereof (*Effective January 1, 2011*):

1196 Each group health insurance policy providing coverage of the type
1197 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
1198 delivered, issued for delivery, renewed, amended or continued in this
1199 state [on or after October 1, 2000,] that provides coverage for ostomy
1200 surgery shall include coverage, up to one thousand dollars annually,
1201 for medically necessary appliances and supplies relating to an ostomy
1202 including, but not limited to, collection devices, irrigation equipment

1203 and supplies, skin barriers and skin protectors. As used in this section,
1204 "ostomy" includes colostomy, ileostomy and urostomy. Payments
1205 under this section shall not be applied to any policy maximums for
1206 durable medical equipment. Nothing in this section shall be deemed to
1207 decrease policy benefits in excess of the limits in this section.

1208 Sec. 30. Subsection (a) of section 38a-527 of the general statutes is
1209 repealed and the following is substituted in lieu thereof (*Effective*
1210 *January 1, 2011*):

1211 (a) Notwithstanding any other provision of the general statutes, [to
1212 the contrary,] no group health insurance policy providing coverage of
1213 the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of
1214 section 38a-469 delivered, issued for delivery, amended, [or] renewed
1215 [on or after October 1, 1984,] or continued in this state may exclude
1216 coverage for a bodily injury solely because it was caused by an
1217 accident arising out of and in the course of employment to a covered
1218 individual who is: (1) A sole proprietor or business partner who is not
1219 covered by the provisions of chapter 568 or who accepts the provisions
1220 of said chapter 568 pursuant to subdivision (6) of section 31-275; or (2)
1221 an employee of a corporation and who is a corporate officer, regardless
1222 of any election by such individual to be excluded from coverage under
1223 said chapter 568 pursuant to subparagraph (E) of subdivision (5) of
1224 section 31-275. [The provisions of this section shall also apply to all
1225 such policies in this state as of the first anniversary date of such policy
1226 on or after October 1, 1984.] The payment of benefits pursuant to this
1227 section shall be subject to any policy provisions [which] that apply to a
1228 claim not resulting from bodily injury caused by an accident arising
1229 out of and in the course of employment.

1230 Sec. 31. Section 38a-538 of the general statutes is repealed and the
1231 following is substituted in lieu thereof (*Effective from passage*):

1232 Each employer shall allow individuals to elect to continue coverage
1233 under a group plan pursuant to federal extension requirements
1234 established by the Consolidated Omnibus Budget Reconciliation Act of
1235 1985, [(P.L. 99-272)] P.L. 99-272, as amended from time to time.

1236 Sec. 32. Section 38a-542 of the general statutes is repealed and the
1237 following is substituted in lieu thereof (*Effective January 1, 2011*):

1238 (a) Each insurance company, hospital service corporation, medical
1239 service corporation, health care center or fraternal benefit society
1240 [which] that delivers, [or] issues for delivery, renews, amends or
1241 continues in this state group health insurance policies providing
1242 coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)
1243 of section 38a-469 shall provide coverage under such policies for
1244 treatment of leukemia, including outpatient chemotherapy,
1245 reconstructive surgery, cost of any nondental prosthesis, including any
1246 maxillo-facial prosthesis used to replace anatomic structures lost
1247 during treatment for head and neck tumors or additional appliances
1248 essential for the support of such prosthesis, outpatient chemotherapy
1249 following surgical procedures in connection with the treatment of
1250 tumors, a wig if prescribed by a licensed oncologist for a patient who
1251 suffers hair loss as a result of chemotherapy, and costs of removal of
1252 any breast implant which was implanted on or before July 1, 1994,
1253 without regard to the purpose of such implantation, which removal is
1254 determined to be medically necessary. Such benefits shall be subject to
1255 the same terms and conditions applicable to all other benefits under
1256 such policies.

1257 (b) Except as provided in subsection (c) of this section, the coverage
1258 required by subsection (a) of this section shall provide at least a yearly
1259 benefit of one thousand dollars for the costs of removal of any breast
1260 implant, five hundred dollars for the surgical removal of tumors, five
1261 hundred dollars for reconstructive surgery, five hundred dollars for
1262 outpatient chemotherapy, three hundred fifty dollars for a wig and
1263 three hundred dollars for a nondental prosthesis, except that for
1264 purposes of the surgical removal of breasts due to tumors the yearly
1265 benefit for prosthesis shall be at least three hundred dollars for each
1266 breast removed.

1267 (c) The coverage required by subsection (a) of this section shall
1268 provide benefits for the reasonable costs of reconstructive surgery on

1269 each breast on which a mastectomy has been performed, and
1270 reconstructive surgery on a nondiseased breast to produce a
1271 symmetrical appearance. Such benefits shall be subject to the same
1272 terms and conditions applicable to all other benefits under such
1273 policies. For the purposes of this subsection, reconstructive surgery
1274 includes, but is not limited to, augmentation mammoplasty, reduction
1275 mammoplasty and mastopexy.

1276 Sec. 33. Subsection (a) of section 38a-546 of the general statutes is
1277 repealed and the following is substituted in lieu thereof (*Effective*
1278 *January 1, 2011*):

1279 (a) In order to assure reasonable continuation of coverage and
1280 extension of benefits to the citizens of this state, each group health
1281 insurance policy, regardless of the number of insureds, providing
1282 coverage of the type specified in subdivisions (1), (2), (3), (4), (11) and
1283 (12) of section 38a-469, delivered, issued for delivery, renewed,
1284 amended or continued in this state [on or after October 1, 1997,] shall,
1285 subject to the provisions of subsection (d), contain those provisions
1286 described in subsections (b) and (d) of section 38a-554.

1287 Sec. 34. Section 38a-556 of the general statutes is repealed and the
1288 following is substituted in lieu thereof (*Effective from passage*):

1289 There is hereby created a nonprofit legal entity to be known as the
1290 Health Reinsurance Association. All insurers, health care centers and
1291 self-insurers doing business in the state, as a condition to their
1292 authority to transact the applicable kinds of health insurance defined
1293 in section 38a-551, shall be members of the association. The association
1294 shall perform its functions under a plan of operation established and
1295 approved under [subdivision] subsection (a) of this section, and shall
1296 exercise its powers through a board of directors established under this
1297 section.

1298 (a) (1) The board of directors of the association shall be made up of
1299 nine individuals selected by participating members, subject to
1300 approval by the commissioner, two of whom shall be appointed by the

1301 commissioner on or before July 1, 1993, to represent health care
1302 centers. To select the initial board of directors, and to initially organize
1303 the association, the commissioner shall give notice to all members of
1304 the time and place of the organizational meeting. In determining
1305 voting rights at the organizational meeting each member shall be
1306 entitled to vote in person or proxy. The vote shall be a weighted vote
1307 based upon the net health insurance premium derived from this state
1308 in the previous calendar year. If the board of directors is not selected
1309 within sixty days after notice of the organizational meeting, the
1310 commissioner may appoint the initial board. In approving or selecting
1311 members of the board, the commissioner may consider, among other
1312 things, whether all members are fairly represented. Members of the
1313 board may be reimbursed from the moneys of the association for
1314 expenses incurred by them as members, but shall not otherwise be
1315 compensated by the association for their services. (2) The board shall
1316 submit to the commissioner a plan of operation for the association
1317 necessary or suitable to assure the fair, reasonable and equitable
1318 administration of the association. The plan of operation shall become
1319 effective upon approval in writing by the commissioner consistent
1320 with the date on which the coverage under sections 38a-505, 38a-546,
1321 as amended by this act, and 38a-551 to 38a-559, inclusive, must be
1322 made available. The commissioner shall, after notice and hearing,
1323 approve the plan of operation provided such plan is determined to be
1324 suitable to assure the fair, reasonable and equitable administration of
1325 the association, and provides for the sharing of association gains or
1326 losses on an equitable proportionate basis. If the board fails to submit a
1327 suitable plan of operation within one hundred eighty days after its
1328 appointment, or if at any time thereafter the board fails to submit
1329 suitable amendments to the plan, the commissioner shall, after notice
1330 and hearing, adopt and promulgate such reasonable rules as are
1331 necessary or advisable to effectuate the provisions of this section. Such
1332 rules shall continue in force until modified by the commissioner or
1333 superseded by a plan submitted by the board and approved by the
1334 commissioner. The plan of operation shall, in addition to requirements
1335 enumerated in sections 38a-505, 38a-546, as amended by this act, and

1336 38a-551 to 38a-559, inclusive: (A) Establish procedures for the handling
1337 and accounting of assets and moneys of the association; (B) establish
1338 regular times and places for meetings of the board of directors; (C)
1339 establish procedures for records to be kept of all financial transactions,
1340 and for the annual fiscal reporting to the commissioner; (D) establish
1341 procedures whereby selections for the board of directors shall be made
1342 and submitted to the commissioner; (E) establish procedures to amend,
1343 subject to the approval of the commissioner, the plan of operations; (F)
1344 establish procedures for the selection of an [administering carrier]
1345 administrator and set forth the powers and duties of the
1346 [administering carrier] administrator; (G) contain additional
1347 provisions necessary or proper for the execution of the powers and
1348 duties of the association; (H) establish procedures for the
1349 advertisement on behalf of all participating carriers of the general
1350 availability of the comprehensive coverage under sections 38a-505,
1351 38a-546, as amended by this act, and 38a-551 to 38a-559, inclusive; (I)
1352 contain additional provisions necessary for the association to qualify as
1353 an acceptable alternative mechanism in accordance with Section 2744
1354 of the Public Health Service Act, as set forth in the Health Insurance
1355 Portability and Accountability Act of 1996, [(P.L. 104-191)] P.L. 104-
1356 191; and (J) contain additional provisions necessary for the association
1357 to qualify as acceptable coverage in accordance with the Pension
1358 Benefit Guaranty Corporation and Trade Adjustment Assistance
1359 programs of the Trade Act of 2002, [(P.L. 107-210)] P.L. 107-210. The
1360 commissioner may adopt regulations in accordance with the
1361 provisions of chapter 54, to establish criteria for the association to
1362 qualify as an acceptable alternative mechanism.

1363 (b) The association shall have the general powers and authority
1364 granted under the laws of this state to carriers to transact the kinds of
1365 insurance defined under section 38a-551, and in addition thereto, the
1366 specific authority to: (1) Enter into contracts necessary or proper to
1367 carry out the provisions and purposes of sections 38a-505, 38a-546, as
1368 amended by this act, and 38a-551 to 38a-559, inclusive; (2) sue or be
1369 sued, including taking any legal actions necessary or proper for
1370 recovery of any assessments for, on behalf of, or against participating

1371 members; (3) take such legal action as necessary to avoid the payment
1372 of improper claims against the association or the coverage provided by
1373 or through the association; (4) establish, with respect to health
1374 insurance provided by or on behalf of the association, appropriate
1375 rates, scales of rates, rate classifications and rating adjustments, such
1376 rates not to be unreasonable in relation to the coverage provided and
1377 the operational expenses of the association; (5) administer any type of
1378 reinsurance program, for or on behalf of participating members; (6)
1379 pool risks among participating members; (7) issue policies of insurance
1380 on an indemnity or provision of service basis providing the coverage
1381 required by sections 38a-505, 38a-546, as amended by this act, and 38a-
1382 551 to 38a-559, inclusive, in its own name or on behalf of participating
1383 members; (8) administer separate pools, separate accounts or other
1384 plans as deemed appropriate for separate members or groups of
1385 members; (9) operate and administer any combination of plans, pools,
1386 reinsurance arrangements or other mechanisms as deemed appropriate
1387 to best accomplish the fair and equitable operation of the association;
1388 (10) set limits on the amounts of reinsurance [which] that may be
1389 ceded to the association by its members; (11) appoint from among
1390 participating members appropriate legal, actuarial and other
1391 committees as necessary to provide technical assistance in the
1392 operation of the association, policy and other contract design, and any
1393 other function within the authority of the association; and (12) apply
1394 for and accept grants, gifts and bequests of funds from other states,
1395 federal and interstate agencies and independent authorities, private
1396 firms, individuals and foundations for the purpose of carrying out its
1397 responsibilities. Any such funds received shall be deposited in the
1398 General Fund and shall be credited to a separate nonlapsing account
1399 within the General Fund for the Health Reinsurance Association and
1400 may be used by the Health Reinsurance Association in the
1401 performance of its duties.

1402 (c) Every member shall participate in the association in accordance
1403 with the provisions of this [subdivision] subsection. (1) A participating
1404 member shall determine the particular risks it elects to have written by
1405 or through the association. A member shall designate which of the

1406 following classes of risks it shall underwrite in the state, from which
1407 classes of risk it may elect to reinsure selected risks: (A) Individual,
1408 excluding group conversion; and (B) individual, including group
1409 conversion. (2) No member shall be permitted to select out individual
1410 lives from an employer group to be insured by or through the
1411 association. Members electing to administer risks [which] that are
1412 insured by or through the association shall comply with the benefit
1413 determination guidelines and the accounting procedures established
1414 by the association. A risk insured by or through the association cannot
1415 be withdrawn by the participating member except in accordance with
1416 the rules established by the association. (3) Rates for coverage issued
1417 by or through the association shall not be excessive, inadequate or
1418 unfairly discriminatory. Separate scales of premium rates based on age
1419 shall apply, but rates shall not be adjusted for area variations in
1420 provider costs. Premium rates shall take into consideration the
1421 substantial extra morbidity and administrative expenses for
1422 association risks, reimbursement or reasonable expenses incurred for
1423 the writing of association risks and the level of rates charged by
1424 insurers for groups of ten lives, provided incurred losses [which] that
1425 result from provision of coverage in accordance with section 38a-537
1426 shall not be considered. In no event shall the rate for a given
1427 classification or group be less than one hundred twenty-five per cent
1428 or more than one hundred fifty per cent of the average rate charged for
1429 that classification with similar characteristics under a policy covering
1430 ten lives. All rates shall be promulgated by the association through an
1431 actuarial committee consisting of five persons who are members of the
1432 American Academy of Actuaries, shall be filed with the commissioner
1433 and may be disapproved within sixty days from the filing thereof if
1434 excessive, inadequate or unfairly discriminatory.

1435 (d) (1) Following the close of each fiscal year, the [administering
1436 carrier] administrator shall determine the net premiums, reinsurance
1437 premiums less administrative expense allowance, the expense of
1438 administration pertaining to the reinsurance operations of the
1439 association and the incurred losses for the year. Any net loss shall be
1440 assessed to all participating members in proportion to their respective

1441 shares of the total health insurance premiums earned in this state
1442 during the calendar year, or with paid losses in the year, coinciding
1443 with or ending during the fiscal year of the association or on any other
1444 equitable basis as may be provided in the plan of operations. For self-
1445 insured members of the association, health insurance premiums
1446 earned shall be established by dividing the amount of paid health
1447 losses for the applicable period by eighty-five per cent. Net gains, if
1448 any, shall be held at interest to offset future losses or allocated to
1449 reduce future premiums. (2) Any net loss to the association
1450 represented by the excess of its actual expenses of administering
1451 policies issued by the association over the applicable expense
1452 allowance shall be separately assessed to those participating members
1453 who do not elect to administer their plans. All assessments shall be on
1454 an equitable formula established by the board. (3) The association shall
1455 conduct periodic audits to assure the general accuracy of the financial
1456 data submitted to the association and the association shall have an
1457 annual audit of its operations by an independent certified public
1458 accountant. The annual audit shall be filed with the commissioner for
1459 his review and the association shall be subject to the provisions of
1460 section 38a-14. (4) For the fiscal year ending December 31, 1993, and
1461 the first quarter of the fiscal year ending December 31, 1994, the
1462 [administering carrier] administrator shall not include health care
1463 centers in assessing any net losses to participating members.

1464 (e) All policy forms issued by or through the association shall
1465 conform in substance to prototype forms developed by the association,
1466 shall in all other respects conform to the requirements of sections 38a-
1467 505, 38a-546, as amended by this act, and 38a-551 to 38a-559, inclusive,
1468 and shall be approved by the commissioner. The commissioner may
1469 disapprove any such form if it contains a provision or provisions
1470 which are unfair or deceptive or which encourage misrepresentation of
1471 the policy.

1472 (f) Unless otherwise permitted by the plan of operation, the
1473 association shall not issue, reissue or continue in force comprehensive
1474 health care plan coverage with respect to any person who is already

1475 covered under an individual or group comprehensive health care plan,
1476 or who is sixty-five years of age or older and eligible for Medicare or
1477 who is not a resident of this state. Coverage provided to a HIPAA or
1478 health care tax credit eligible individual may be terminated to the
1479 extent permitted by HIPAA or the Trade Act of 2002, respectively.

1480 (g) Benefits payable under a comprehensive health care plan
1481 insured by or reinsured through the association shall be paid net of all
1482 other health insurance benefits paid or payable through any other
1483 source, and net of all health insurance coverages provided by or
1484 pursuant to any other state or federal law including Title XVIII of the
1485 Social Security Act, Medicare, but excluding Medicaid.

1486 (h) There shall be no liability on the part of and no cause of action of
1487 any nature shall arise against any carrier or its agents or its employees,
1488 the Health Reinsurance Association or its agents or its employees or
1489 the residual market mechanism established under the provisions of
1490 section 38a-557 or its agents or its employees, or the commissioner or
1491 his representatives for any action taken by them in the performance of
1492 their duties under sections 38a-505, 38a-546, as amended by this act,
1493 and 38a-551 to 38a-559, inclusive. This provision shall not apply to the
1494 obligations of a carrier, a self-insurer, the Health Reinsurance
1495 Association or the residual market mechanism for payment of benefits
1496 provided under a comprehensive health care plan.

1497 Sec. 35. Subdivisions (3) and (4) of section 38a-564 of the general
1498 statutes are repealed and the following is substituted in lieu thereof
1499 (*Effective from passage*):

1500 (3) "Eligible employee" means an employee who works on a full-
1501 time basis, with a normal work week of thirty or more hours and
1502 includes a sole proprietor, a partner of a partnership or an
1503 independent contractor, provided such sole proprietor, partner or
1504 contractor is included as an employee under a health care plan of a
1505 small employer but does not include an employee who works on a
1506 part-time, temporary or substitute basis. "Eligible employee" shall
1507 include any employee who is not actively at work but is covered under

1508 the small employer's health insurance plan pursuant to (A) workers'
1509 compensation, (B) continuation of benefits pursuant to federal
1510 extension requirements established by the Consolidated Omnibus
1511 Budget Reconciliation Act of 1985, [(P.L. 99-272)] P.L. 99-272, as
1512 amended from time to time, [(COBRA)] or (C) other applicable laws.
1513 [Such employees shall not be counted as eligible employees for the
1514 purposes of subsection (4) of this section.]

1515 (4) (A) "Small employer" means any person, firm, corporation,
1516 limited liability company, partnership or association actively engaged
1517 in business or self-employed for at least three consecutive months
1518 who, on at least fifty per cent of its working days during the preceding
1519 twelve months, employed no more than fifty eligible employees, the
1520 majority of whom were employed within the state of Connecticut.
1521 "Small employer" includes a self-employed individual. [In] For the
1522 purposes of determining the number of eligible employees [,
1523 companies which] under this subdivision: (i) Companies that are
1524 affiliated companies, as defined in section 33-840, or [which] that are
1525 eligible to file a combined tax return for purposes of taxation under
1526 chapter 208 shall be considered one employer; [Eligible employees
1527 shall not include] (ii) employees covered through the employer by
1528 health insurance plans or insurance arrangements issued to or in
1529 accordance with a trust established pursuant to collective bargaining
1530 subject to the federal Labor Management Relations Act shall not be
1531 counted; and (iii) employees who are not actively at work but are
1532 covered under the small employer's health insurance plan pursuant to
1533 workers' compensation, continuation of benefits pursuant to federal
1534 extension requirements established by the Consolidated Omnibus
1535 Budget Reconciliation Act of 1985, P.L. 99-272, as amended from time
1536 to time, or other applicable laws shall not be counted. Except as
1537 otherwise specifically provided, provisions of sections 12-201, 12-211,
1538 12-212a and 38a-564 to 38a-572, inclusive, as amended by this act, that
1539 apply to a small employer shall continue to apply until the plan
1540 anniversary following the date the employer no longer meets the
1541 requirements of this definition.

1542 (B) "Small employer" does not include (i) a municipality procuring
1543 health insurance pursuant to section 5-259, (ii) a private school in this
1544 state procuring health insurance through a health insurance plan or an
1545 insurance arrangement sponsored by an association of such private
1546 schools, (iii) a nonprofit organization procuring health insurance
1547 pursuant to section 5-259, unless the Secretary of the Office of Policy
1548 and Management and the State Comptroller make a request in writing
1549 to the Insurance Commissioner that such nonprofit organization be
1550 deemed a small employer for the purposes of this chapter, (iv) an
1551 association for personal care assistants procuring health insurance
1552 pursuant to section 5-259, or (v) a community action agency procuring
1553 health insurance pursuant to section 5-259.

1554 Sec. 36. Section 38a-569 of the general statutes is repealed and the
1555 following is substituted in lieu thereof (*Effective from passage*):

1556 (a) (1) There is established a nonprofit entity to be known as the
1557 "Connecticut Small Employer Health Reinsurance Pool". All insurers
1558 issuing health insurance in this state and insurance arrangements
1559 providing health plan benefits in this state on and after July 1, 1990,
1560 shall be members of the pool.

1561 (2) On or before July 15, 1990, the commissioner shall give notice to
1562 all insurers and insurance arrangements of the time and place for the
1563 initial organizational meeting, which shall take place by September 1,
1564 1990. The members shall select the initial board, subject to approval by
1565 the commissioner. The board shall consist of at least five and not more
1566 than nine representatives of members. There shall be no more than two
1567 members of the board representing any one insurer or insurance
1568 arrangement. In determining voting rights at the organizational
1569 meeting, each member shall be entitled to vote in person or by proxy.
1570 The vote shall be weighted based upon net health insurance premium
1571 derived from this state in the previous calendar year. To the extent
1572 possible, at least one-third of the members of the board shall be
1573 domestic insurance companies and at least two-thirds of the members
1574 of the board shall be small employer carriers. At least one member of

1575 the board shall be a health care center and at least one member shall be
1576 a small employer carrier with less than one hundred million dollars in
1577 net small employer health insurance premium in this state. The
1578 Insurance Commissioner shall be an ex-officio member of the board.
1579 The net premium amount shall be adjusted by the board periodically
1580 for health care cost inflation. In approving selection of the board, the
1581 commissioner shall assure that all members are fairly represented. The
1582 membership of all boards subsequent to the initial board shall, to the
1583 extent possible, reflect the same distribution of representation as is
1584 described in this subdivision.

1585 (3) If the initial board is not elected at the organizational meeting,
1586 the commissioner shall appoint the initial board within fifteen days of
1587 the organizational meeting.

1588 (4) Within ninety days after the appointment of such initial board,
1589 the board shall submit to the commissioner a plan of operation and
1590 thereafter any amendments thereto necessary or suitable to assure the
1591 fair, reasonable and equitable administration of the pool. The
1592 commissioner shall, after notice and hearing, approve the plan of
1593 operation provided he determines it to be suitable to assure the fair,
1594 reasonable and equitable administration of the pool, and provides for
1595 the sharing of pool gains or losses on an equitable proportionate basis
1596 in accordance with the provisions of subsection (d) of this section. The
1597 plan of operation shall become effective upon approval in writing by
1598 the commissioner consistent with the date on which the coverage
1599 under this section shall be made available. If the board fails to submit a
1600 suitable plan of operation within one hundred eighty days after its
1601 appointment, or at any time thereafter fails to submit suitable
1602 amendments to the plan of operation, the commissioner shall, after
1603 notice and hearing, adopt and promulgate a plan of operation or
1604 amendments, as appropriate. The commissioner shall amend any plan
1605 adopted by him, as necessary, at the time a plan of operation is
1606 submitted by the board and approved by the commissioner.

1607 (5) The plan of operation shall establish procedures for: (A)

1608 Handling and accounting of assets and moneys of the pool, and for an
1609 annual fiscal reporting to the commissioner; (B) filling vacancies on the
1610 board, subject to the approval of the commissioner; (C) selecting an
1611 [administering insurer] administrator and setting forth the powers and
1612 duties of the [administering insurer] administrator; (D) reinsuring risks
1613 in accordance with the provisions of this section; (E) collecting
1614 assessments from all members to provide for claims reinsured by the
1615 pool and for administrative expenses incurred or estimated to be
1616 incurred during the period for which the assessment is made; and (F)
1617 any additional matters at the discretion of the board.

1618 (6) The pool shall have the general powers and authority granted
1619 under the laws of Connecticut to insurance companies licensed to
1620 transact health insurance and, in addition thereto, the specific
1621 authority to: (A) Enter into contracts as are necessary or proper to
1622 carry out the provisions and purposes of this section, including the
1623 authority, with the approval of the commissioner, to enter into
1624 contracts with programs of other states for the joint performance of
1625 common functions, or with persons or other organizations for the
1626 performance of administrative functions; (B) sue or be sued, including
1627 taking any legal actions necessary or proper for recovery of any
1628 assessments for, on behalf of, or against members; (C) take such legal
1629 action as necessary to avoid the payment of improper claims against
1630 the pool; (D) define the array of health coverage products for which
1631 reinsurance will be provided, and to issue reinsurance policies, in
1632 accordance with the requirements of this section; (E) establish rules,
1633 conditions and procedures pertaining to the reinsurance of members'
1634 risks by the pool; (F) establish appropriate rates, rate schedules, rate
1635 adjustments, rate classifications and any other actuarial functions
1636 appropriate to the operation of the pool; (G) assess members in
1637 accordance with the provisions of subsection (e) of this section, and to
1638 make advance interim assessments as may be reasonable and
1639 necessary for organizational and interim operating expenses. Any such
1640 interim assessments shall be credited as offsets against any regular
1641 assessments due following the close of the fiscal year; (H) appoint from
1642 among members appropriate legal, actuarial and other committees as

1643 necessary to provide technical assistance in the operation of the pool,
1644 policy and other contract design, and any other function within the
1645 authority of the pool; and (I) borrow money to effect the purposes of
1646 the pool. Any notes or other evidence of indebtedness of the pool not
1647 in default shall be legal investments for insurers and may be carried as
1648 admitted assets.

1649 (b) Any member may reinsure with the pool coverage of an eligible
1650 employee of a small employer, or any dependent of such an employee,
1651 except that no member may reinsure with the pool coverage of an
1652 eligible employee of a small employer, or any dependent of such an
1653 employee, whose premium rates are not subject to section 38a-567
1654 pursuant to subdivision (22) of section 38a-567. Any reinsurance
1655 placed with the pool from the date of the establishment of the pool
1656 regarding the coverage of an eligible employee of a small employer, or
1657 any dependent of such an employee shall be provided as follows:

1658 (1) (A) With respect to a special health care plan or a small employer
1659 health care plan, the pool shall reinsure the level of coverage provided;
1660 (B) with respect to other plans, the pool shall reinsure the level of
1661 coverage provided up to, but not exceeding, the level of coverage
1662 provided in a small employer health care plan or the actuarial
1663 equivalent thereof as defined and authorized by the board; and (C) in
1664 either case, no reinsurance may be provided in any calendar year for a
1665 reinsured employee or dependent until five thousand dollars in benefit
1666 payments have been made for services provided during that calendar
1667 year for that reinsured employee or dependent, which payments
1668 would have been reimbursed through said reinsurance in the absence
1669 of the annual five-thousand-dollar deductible. The amount of the
1670 deductible shall be periodically reviewed by the board and may be
1671 adjusted for appropriate factors as determined by the board;

1672 (2) With respect to eligible employees, and their dependents,
1673 coverage may be reinsured: (A) Within such period of time after the
1674 commencement of their coverage under the plan as may be authorized
1675 by the board, or (B) commencing January 1, 1992, on the first plan

1676 anniversary after the employer's coverage has been in effect with the
1677 small employer carrier for a period of three years, and every third plan
1678 anniversary thereafter, provided, commencing May 1, 1994,
1679 reinsurance pursuant to this subparagraph shall only be permitted
1680 with respect to eligible employees and their dependents of a small
1681 employer which has no more than two eligible employees as of the
1682 applicable anniversary;

1683 (3) Reinsurance coverage may be terminated for each reinsured
1684 employee or dependent on any plan anniversary;

1685 (4) Reinsurance of newborn dependents shall be allowed only if the
1686 mother of any such dependent is reinsured as of the date of birth of
1687 such child, and all newborn dependents of reinsured persons shall be
1688 automatically reinsured as of their date of birth; and

1689 (5) Notwithstanding the provisions of subparagraph (A) of
1690 subdivision (2) of this subsection: (A) Coverage for eligible employees
1691 and their dependents provided under a group policy covering two or
1692 more small employers shall not be eligible for reinsurance when such
1693 coverage is discontinued and replaced by a group policy of another
1694 carrier covering two or more small employers, unless coverage for
1695 such eligible employees or dependents was reinsured by the prior
1696 carrier; and (B) at the time coverage is assumed for such group by a
1697 succeeding carrier, such carrier shall notify the pool of its intention to
1698 provide coverage for such group and shall identify the employees and
1699 dependents whose coverage will continue to be reinsured. The time
1700 limitations for providing such notice shall be established by the pool.

1701 (c) Except as provided in subsection (d) of this section, premium
1702 rates charged for reinsurance by the pool shall be established at the
1703 following percentages of the rate established by the pool for that
1704 classification or group with similar characteristics and coverage:

1705 (1) One hundred fifty per cent, with respect to all of the eligible
1706 employees, and their dependents, of a small employer, all of whose
1707 coverage is reinsured in accordance with subdivision (2) of subsection

1708 (b) of this section; and

1709 (2) Five hundred per cent, with respect to an eligible employee or
1710 dependent who is individually reinsured in accordance with
1711 subdivision (2) of subsection (b) of this section and is not reinsured
1712 with all eligible employees of an employer and their dependents.

1713 (d) Premium rates charged for reinsurance by the pool to a health
1714 care center which is approved by the Secretary of Health and Human
1715 Services as a health maintenance organization pursuant to 42 USC 300
1716 et seq., and as such is subject to requirements that limit the amount of
1717 risk that may be ceded to the pool, may be modified by the board, if
1718 appropriate, to reflect the portion of risk that may be ceded to the pool.

1719 (e) (1) Following the close of each fiscal year, the [administering
1720 insurer] administrator shall determine the net premiums, the pool
1721 expenses of administration and the incurred losses for the year, taking
1722 into account investment income and other appropriate gains and
1723 losses. For purposes of this section, health insurance premiums earned
1724 by insurance arrangements shall be established by adding paid health
1725 losses and administrative expenses of the insurance arrangement.
1726 Health insurance premiums and benefits paid by a member that are
1727 less than an amount determined by the board to justify the cost of
1728 collection shall not be considered for purposes of determining
1729 assessments. For purposes of this subsection, "net premiums" means
1730 health insurance premiums, less administrative expense allowances.

1731 (2) Any net loss for the year shall be recouped by assessments of
1732 members. (A) Assessments shall first be apportioned by the board
1733 among all members in proportion to their respective shares of the total
1734 health insurance premiums earned in this state from health insurance
1735 plans and insurance arrangements covering small employers during
1736 the calendar year coinciding with or ending during the fiscal year of
1737 the pool, or on any other equitable basis reflecting coverage of small
1738 employers as may be provided in the plan of operations. An
1739 assessment shall be made pursuant to this subparagraph against a
1740 health care center, which is approved by the Secretary of Health and

1741 Human Services as a health maintenance organization pursuant to 42
1742 USC 300e et seq., subject to an assessment adjustment formula adopted
1743 by the board and approved by the commissioner for such health care
1744 centers which recognizes the restrictions imposed on such health care
1745 centers by federal law. Such adjustment formula shall be adopted by
1746 the board and approved by the commissioner prior to the first
1747 anniversary of the pool's operation. (B) If such net loss is not recouped
1748 before assessments totaling five per cent of such premiums from plans
1749 and arrangements covering small employers have been collected,
1750 additional assessments shall be apportioned by the board among all
1751 members in proportion to their respective shares of the total health
1752 insurance premiums earned in this state from other individual and
1753 group plans and arrangements, exclusive of any individual Medicare
1754 supplement policies as defined in section 38a-495 during such calendar
1755 year. (C) Notwithstanding the provisions of this subdivision, the
1756 assessments to any one member under subparagraph (A) or (B) of this
1757 subdivision shall not exceed forty per cent of the total assessment
1758 under each subparagraph for the first fiscal year of the pool's operation
1759 and fifty per cent of the total assessment under each subparagraph for
1760 the second fiscal year. Any amounts abated pursuant to this
1761 subparagraph shall be assessed against the other members in a manner
1762 consistent with the basis for assessments set forth in this subdivision.

1763 (3) If assessments exceed actual losses and administrative expenses
1764 of the pool, the excess shall be held at interest and used by the board to
1765 offset future losses or to reduce pool premiums. As used in this
1766 subsection, "future losses" includes reserves for incurred but not
1767 reported claims.

1768 (4) Each member's proportion of participation in the pool shall be
1769 determined annually by the board based on annual statements and
1770 other reports deemed necessary by the board and filed by the member
1771 with it. Insurance arrangements shall report to the board claims
1772 payments made and administrative expenses incurred in this state on
1773 an annual basis on a form prescribed by the commissioner.

1774 (5) Provision shall be made in the plan of operation for the
1775 imposition of an interest penalty for late payment of assessments.

1776 (6) The board may defer, in whole or in part, the assessment of a
1777 health care center if, in the opinion of the board: (A) Payment of the
1778 assessment would endanger the ability of the health care center to
1779 fulfill its contractual obligations, or (B) in accordance with standards
1780 included in the plan of operation, the health care center has written,
1781 and reinsured in their entirety, a disproportionate number of special
1782 health care plans. In the event an assessment against a health care
1783 center is deferred in whole or in part, the amount by which such
1784 assessment is deferred may be assessed against the other members in a
1785 manner consistent with the basis for assessments set forth in this
1786 subsection. The health care center receiving such deferment shall
1787 remain liable to the pool for the amount deferred. The board may
1788 attach appropriate conditions to any such deferment.

1789 (f) (1) Neither the participation in the pool as members, the
1790 establishment of rates, forms or procedures nor any other joint or
1791 collective action required by this section shall be the basis of any legal
1792 action, criminal or civil liability or penalty against the pool or any of its
1793 members.

1794 (2) Any person or member made a party to any action, suit [,] or
1795 proceeding because the person or member served on the board or on a
1796 committee or was an officer or employee of the pool shall be held
1797 harmless and be indemnified by the program against all liability and
1798 costs, including the amounts of judgments, settlements, fines or
1799 penalties, and expenses and reasonable attorney's fees incurred in
1800 connection with the action, suit or proceeding. The indemnification
1801 shall not be provided on any matter in which the person or member is
1802 finally adjudged in the action, suit or proceeding to have committed a
1803 breach of duty involving gross negligence, dishonesty, wilful
1804 misfeasance or reckless disregard of the responsibilities of office. Costs
1805 and expenses of the indemnification shall be prorated and paid for by
1806 all members. The Insurance Commissioner may retain actuarial

1807 consultants necessary to carry out [his] said commissioner's
1808 responsibilities pursuant to sections 38a-564 to 38a-572, inclusive, as
1809 amended by this act, and such expenses shall be paid by the pool
1810 established in this section.

1811 Sec. 37. Subdivision (7) of section 38a-760a of the general statutes is
1812 repealed and the following is substituted in lieu thereof (*Effective from*
1813 *passage*):

1814 (7) "Reinsurance intermediary-manager" means any person, firm,
1815 association or corporation who has authority to bind or manages all or
1816 part of the assumed reinsurance business of a reinsurer, including the
1817 management of a separate division, department or underwriting office,
1818 and acts as an agent for such reinsurer whether known as a
1819 reinsurance intermediary-manager, manager or other similar term.
1820 Notwithstanding any provision [to the contrary] of the general
1821 statutes, the following persons shall not be considered a reinsurance
1822 intermediary-manager, with respect to such reinsurer, for the purposes
1823 of sections 38a-760 to 38a-760i, inclusive: (A) An employee of the
1824 reinsurer; (B) a United States manager of the United States branch of
1825 an alien reinsurer; (C) an underwriting manager [which] that, pursuant
1826 to contract, manages all or part of the reinsurance operations of the
1827 reinsurer, is under common control with the reinsurer, subject to
1828 sections 38a-129 to 38a-140, inclusive, and whose compensation is not
1829 based on the volume of premiums written; (D) the manager of a group,
1830 association, pool or organization of insurers [which] that engages in
1831 joint underwriting or joint reinsurance and [who are] that is subject to
1832 examination by the insurance commissioner of the state in which the
1833 manager's principal business office is located;

1834 Sec. 38. Subdivision (2) of subsection (d) of section 38a-790 of the
1835 general statutes is repealed and the following is substituted in lieu
1836 thereof (*Effective from passage*):

1837 (2) "Motor vehicle physical damage appraiser" means any person,
1838 partnership, association, limited liability company or corporation
1839 [which] that practices as a business the appraising of damages to

1840 motor vehicles insured under automobile physical damage policies or
1841 on behalf of third party claimants.

1842 Sec. 39. Section 38a-839 of the general statutes is repealed and the
1843 following is substituted in lieu thereof (*Effective from passage*):

1844 There is created a nonprofit unincorporated legal entity to be known
1845 as the Connecticut Insurance Guaranty Association. All insurers
1846 defined as member insurers in subdivision (8) of section 38a-838 shall
1847 be members of said association as a condition of their authority to
1848 transact insurance in this state. Said association shall perform its
1849 functions under a plan of operation established and approved under
1850 section 38a-842, as amended by this act, and shall exercise its powers
1851 through a board of directors established under section 38a-840, as
1852 amended by this act. For the purposes of administration and
1853 assessment, said association shall be divided into three separate
1854 accounts: [(a)] (1) The workers' compensation insurance account; [(b)]
1855 (2) the automobile insurance account; and [(c)] (3) an account for all
1856 other insurance to which sections 38a-836 to 38a-853, inclusive, apply.

1857 Sec. 40. Section 38a-840 of the general statutes is repealed and the
1858 following is substituted in lieu thereof (*Effective from passage*):

1859 [(1)] (a) The board of directors of said association shall consist of not
1860 less than five nor more than nine persons serving terms as established
1861 in the plan of operation under section 38a-842, as amended by this act.
1862 The members of the board of directors shall be selected by member
1863 insurers subject to the approval of the commissioner. Vacancies on the
1864 board shall be filled for the remaining period of the term by a majority
1865 vote of the remaining members, subject to the approval of the
1866 commissioner. If no members are selected within sixty days after
1867 October 1, 1971, the commissioner may appoint the initial members of
1868 the board of directors.

1869 [(2)] (b) In approving selections to said board, the commissioner
1870 shall consider among other things whether all member insurers are
1871 fairly represented.

1872 [(3)] (c) Members of said board shall receive no compensation as
1873 such but shall be reimbursed from the assets of said association for
1874 actual and necessary expenses incurred by them in carrying out their
1875 official duties as members of the board of directors.

1876 Sec. 41. Section 38a-841 of the general statutes is repealed and the
1877 following is substituted in lieu thereof (*Effective from passage*):

1878 [(1)] (a) Said association shall: [(a)] (1) Be obligated to the extent of
1879 the covered claims existing prior to the determination of insolvency
1880 and arising within thirty days after the determination of insolvency, or
1881 before the policy expiration date if less than thirty days after the
1882 determination, or before the insured replaces the policy or causes its
1883 cancellation, if he does so within thirty days of such determination,
1884 provided such obligation shall be limited as follows: [(i)] (A) With
1885 respect to covered claims for unearned premiums, to one-half of the
1886 unearned premium on any policy, subject to a maximum of two
1887 thousand dollars per policy; [(ii)] (B) with respect to covered claims
1888 other than for unearned premiums, such obligation shall include only
1889 that amount of each such claim which is in excess of one hundred
1890 dollars and is less than three hundred thousand dollars for claims
1891 arising under policies of insurers determined to be insolvent prior to
1892 October 1, 2007, and four hundred thousand dollars for claims arising
1893 under policies of insurers determined to be insolvent on or after
1894 October 1, 2007, except that said association shall pay the full amount
1895 of any such claim arising out of a workers' compensation policy,
1896 provided in no event shall [(A) said association be obligated] said
1897 association be obligated (i) to any claimant in an amount in excess of
1898 the obligation of the insolvent insurer under the policy form or
1899 coverage from which the claim arises, or [(B) said association be
1900 obligated] (ii) for any claim filed with the association after the
1901 expiration of two years from the date of the declaration of insolvency
1902 unless such claim arose out of a workers' compensation policy and was
1903 timely filed in accordance with section 31-294c; [(b)] (2) be deemed the
1904 insurer to the extent of its obligations on the covered claims and to
1905 such extent shall have all rights, duties, and obligations of the

1906 insolvent insurer as if the insurer had not become insolvent; [(c)] (3)
1907 allocate claims paid and expenses incurred among the three accounts,
1908 created by section 38a-839, as amended by this act, separately, and
1909 assess member insurers separately [(i)] (A) in respect of each such
1910 account for such amounts as shall be necessary to pay the obligations
1911 of said association under subdivision [(a)] (1) of subsection [(1)] (a) of
1912 this section subsequent to an insolvency; [(ii)] (B) the expenses of
1913 handling covered claims subsequent to an insolvency; [(iii)] (C) the
1914 cost of examinations under section 38a-846; and [(iv)] (D) such other
1915 expenses as are authorized by sections 38a-836 to 38a-853, inclusive.
1916 The assessments of each member insurer shall be in the proportion that
1917 the net direct written premiums of such member insurer for the
1918 calendar year preceding the assessment on the kinds of insurance in
1919 such account bears to the net direct written premiums of all member
1920 insurers for the calendar year preceding the assessment on the kinds of
1921 insurance in such account. Each member insurer shall be notified of its
1922 assessment not later than thirty days before it is due. No member
1923 insurer may be assessed in any year on any account an amount greater
1924 than two per cent of that member insurer's net direct written
1925 premiums for the calendar year preceding the assessment on the kinds
1926 of insurance in said account, provided if, at the time an assessment is
1927 levied on the "all other insurance" account, as defined in subdivision
1928 [(c)] (3) of section 38a-839, as amended by this act, the board of
1929 directors finds that at least fifty per cent of the total net direct written
1930 premiums of a member insurer and all its affiliates, for the year on
1931 which such assessment is based, were from policies issued or delivered
1932 in Connecticut, on risks located in this state, such member insurer shall
1933 be assessed only on such member insurer's net direct written premium
1934 that is attributable to the kind of insurance that gives rise to each
1935 covered claim. If the maximum assessment, together with the other
1936 assets of said association in any account, does not provide in any one
1937 year in any account an amount sufficient to make all necessary
1938 payments from that account, the funds available may be prorated and
1939 the unpaid portion shall be paid as soon thereafter as funds become
1940 available. Said association may defer, in whole or in part, the

1941 assessment of any member insurer, if the assessment would cause the
1942 member insurer's financial statement to reflect amounts of capital or
1943 surplus less than the minimum amounts required for a certificate of
1944 authority by any jurisdiction in which the member insurer is
1945 authorized to transact insurance provided that during the period of
1946 deferment, no dividends shall be paid to shareholders or
1947 policyholders. Deferred assessments shall be paid when such payment
1948 will not reduce capital or surplus below the minimum amounts
1949 required for a certificate of authority. Such payments shall be refunded
1950 to those insurers receiving greater assessments because of such
1951 deferment or, at the election of the insurer, be credited against future
1952 assessments. Each member insurer serving as a servicing facility may
1953 set off against any assessment, authorized payments made on covered
1954 claims and expenses incurred in the payment of such claims by such
1955 member insurer if they are chargeable to the account in respect of
1956 which the assessment is made; [(d)] (4) investigate claims brought
1957 against said association and adjust, compromise, settle, and pay
1958 covered claims to the extent of said association's obligations, and deny
1959 all other claims. The association shall pay claims in any order it deems
1960 reasonable, including but not limited to, payment in the order of
1961 receipt or by classification. It may review settlements, releases and
1962 judgments to which the insolvent insurer or its insureds were parties
1963 to determine the extent to which such settlements, releases and
1964 judgments may be properly contested; [(e)] (5) notify such persons as
1965 the commissioner may direct under subdivision [(a)] (1) of subsection
1966 [(2)] (b) of section 38a-843, as amended by this act; [(f)] (6) handle
1967 claims through its employees or through one or more insurers or other
1968 persons designated by said association as servicing facilities, provided
1969 such designation of a servicing facility shall be subject to the approval
1970 of the commissioner, and may be declined by a member insurer; [(g)]
1971 (7) reimburse each such servicing facility for obligations of said
1972 association paid by such facility and for expenses incurred by such
1973 facility while handling claims on behalf of said association and shall
1974 pay such other expenses of said association as are authorized by
1975 sections 38a-836 to 38a-853, inclusive.

1976 [(2)] (b) Said association may: [(a)] (1) Employ or retain such persons
1977 as are necessary to handle claims and perform other duties of said
1978 association; [(b)] (2) borrow such funds as may be necessary from time
1979 to time to effect the purposes of sections 38a-836 to 38a-853, inclusive,
1980 in accord with the plan of operation under section 38a-842, as
1981 amended by this act; [(c)] (3) sue or be sued; [(d)] (4) intervene as a
1982 matter of right as a party in any proceeding before any court in this
1983 state that has jurisdiction over an insolvent insurer, as defined in
1984 section 38a-838; [(e)] (5) negotiate and become a party to such contracts
1985 as are necessary to carry out the purpose of said sections; [(f)] (6)
1986 perform such other acts as are necessary or proper to effectuate the
1987 purpose of said sections; [(g)] (7) refund to the member insurers in
1988 proportion to the contribution of each such member insurer to that
1989 account, that amount by which the assets of the account exceed the
1990 liabilities, if, at the end of any calendar year, the board of directors
1991 finds that the assets of said association in any account exceed the
1992 liabilities of that account as estimated by the board of directors for the
1993 coming year.

1994 [(3) (A)] (c) (1) Each insurer paying an assessment under sections
1995 38a-836 to 38a-853, inclusive, may offset one hundred per cent of the
1996 amount of such assessment against its premium tax liability to this
1997 state under chapter 207. Such offset shall be taken over a period of the
1998 five successive tax years following the year of payment of the
1999 assessment, at the rate of twenty per cent per year of the assessment
2000 paid to the association. Each insurer to which has been refunded by the
2001 association, pursuant to [subdivision (2)] subsection (b) of this section,
2002 all or a portion of an assessment previously paid to the association by
2003 the insurer shall be required to pay to the Department of Revenue
2004 Services an amount equal to the total amount that has been claimed as
2005 an offset against the premiums tax liability on the premiums tax return
2006 or returns, as the case may be, filed by such insurer and that is
2007 attributable to such refunded assessment, provided the amount
2008 required to be paid to said department shall not exceed the amount of
2009 the refunded assessment. If the amount of the refunded assessment
2010 exceeds the total amount that has been claimed as an offset against the

2011 premiums tax liability on the premiums tax return or returns filed by
2012 such insurer and that is attributable to such refunded assessment, such
2013 excess may not be claimed as an offset against the premiums tax
2014 liability on a premiums tax return or returns filed by such insurer or, if
2015 the offset has been transferred to another person pursuant to
2016 [subparagraph (B)] subdivision (2) of this [subdivision] subsection, by
2017 such other person. For purposes of this subparagraph, if the offset has
2018 been transferred to another person pursuant to [subparagraph (B)]
2019 subdivision (2) of this [subdivision] subsection, the total amount that
2020 has been claimed as an offset against the premiums tax liability on the
2021 premiums tax return or returns filed by such insurer includes the total
2022 amount that has been claimed as an offset against the premiums tax
2023 liability on the premiums tax return or returns filed by such other
2024 person. The association shall promptly notify the Commissioner of
2025 Revenue Services of the name and address of the insurers to which
2026 such refunds have been made, the amount of such refunds and the
2027 date on which such refunds were mailed to such insurer. If the amount
2028 that an insurer is required to pay to the Department of Revenue
2029 Services has not been so paid on or before the forty-fifth day after the
2030 date of mailing of such refunds, the insurer shall be liable for interest
2031 on such amount at the rate of one per cent per month or fraction
2032 thereof from such forty-fifth day to the date of payment.

2033 [(B)] (2) An insurer, in this subparagraph called "the transferor",
2034 may transfer any offset provided under [subparagraph (A)]
2035 subdivision (1) of this [subdivision] subsection to an affiliate, as
2036 defined in section 38a-1, of the transferor. Any such transfer of the
2037 offset by the transferor and any subsequent transfer or transfers of the
2038 same offset shall not affect the obligation of the transferor to pay to the
2039 Department of Revenue Services any sums which are acquired by
2040 refund from the association pursuant to [subdivision (2)] subsection (b)
2041 of this section and which are required to be paid to the Department of
2042 Revenue Services pursuant to [subparagraph (A)] subdivision (1) of
2043 this [subdivision] subsection. Such offset may be taken by any
2044 transferee only against the transferee's premium tax liability to this
2045 state under chapter 207. The Commissioner of Revenue Services shall

2046 not allow such offset to a transferee against its premium tax liability
2047 unless the transferor, the affiliate to which the offset was originally
2048 transferred, each subsequent transferor and each subsequent transferee
2049 have filed such information as may be required on forms provided by
2050 said commissioner with respect to any such transfer or transfers on or
2051 before the due date of the premium tax return on which such offset
2052 would have been taken by the transferor if no transfer had been made
2053 by the transferor.

2054 Sec. 42. Section 38a-842 of the general statutes is repealed and the
2055 following is substituted in lieu thereof (*Effective from passage*):

2056 [(1)] (a) (1) Said association shall submit to the commissioner a plan
2057 of operation and any amendments thereto necessary or suitable to
2058 assure the fair, reasonable, and equitable administration of said
2059 association. The plan of operation and any amendments thereto shall
2060 become effective upon approval in writing by the commissioner.

2061 [(b)] (2) If said association fails to submit a suitable plan of operation
2062 within ninety days following October 1, 1971, or if at any time
2063 thereafter said association fails to submit suitable amendments to the
2064 plan, the commissioner shall, after notice and hearing, adopt and
2065 promulgate such reasonable regulations as are necessary or advisable
2066 to effectuate the provisions of sections 38a-836 to 38a-853, inclusive.
2067 Such regulations shall continue in force until modified by the
2068 commissioner or superseded by a plan submitted by said association
2069 and approved by the commissioner.

2070 [(2)] (b) All member insurers shall comply with the plan of
2071 operation.

2072 [(3)] (c) The plan of operation shall: [(a)] (1) Establish the procedures
2073 whereby all the powers and duties of said association under section
2074 38a-841, as amended by this act, shall be performed; [(b)] (2) establish
2075 procedures for handling the assets of said association; [(c)] (3) establish
2076 the number, the terms of office and the amount and method of
2077 reimbursing members of the board of directors under section 38a-840,

2078 as amended by this act; [(d)] (4) establish procedures by which claims
2079 may be filed with said association and establish acceptable forms of
2080 proof of covered claims. Notice of claims to the receiver or liquidator
2081 of the insolvent insurer shall be deemed notice to said association or its
2082 agent and a list of such claims shall be periodically submitted to said
2083 association or similar organization having a like function to that of said
2084 association in another state by the receiver or liquidator; [(e)] (5)
2085 establish regular places and times for meetings of the board of
2086 directors; [(f)] (6) establish procedures for records to be kept of all
2087 financial transactions of said association, its agents, and the board of
2088 directors; [(g)] (7) provide that any member insurer aggrieved by any
2089 final action or decision of said association may appeal to the
2090 commissioner within thirty days after such action or decision; [(h)] (8)
2091 establish the procedures whereby selections for the board of directors
2092 shall be submitted to the commissioner; [(i)] (9) contain such additional
2093 provisions as may be necessary or proper for the execution of the
2094 powers and duties of said association under sections 38a-836 to 38a-
2095 853, inclusive.

2096 [(4)] (d) The plan of operation may delegate any or all powers and
2097 duties of said association, except those under subdivision [(c)] (3) of
2098 subsection [(1)] (a) of section 38a-841, as amended by this act, and
2099 subdivision [(b)] (2) of subsection [(2)] (b) of section 38a-841, as
2100 amended by this act, to a corporation, association, or other
2101 organization which performs or will perform functions similar to those
2102 of said association, or its equivalent having a like function to that of
2103 said association, in two or more states. Such a corporation, association
2104 or organization shall be reimbursed by said association as a servicing
2105 facility would be reimbursed and shall be paid by said association for
2106 its performance of any other functions of said association. Any
2107 delegation under this subsection shall take effect only with the
2108 approval of both the board of directors and the commissioner, and
2109 may be made only to a corporation, association, or organization which
2110 extends protection not substantially less favorable and effective than
2111 that provided by sections 38a-836 to 38a-853, inclusive.

2112 Sec. 43. Section 38a-843 of the general statutes is repealed and the
2113 following is substituted in lieu thereof (*Effective from passage*):

2114 [(1)] (a) The commissioner shall: [(a)] (1) Notify said association of
2115 the existence of an insolvent insurer, and notify the chairman of the
2116 Workers' Compensation Commission and the State Treasurer of the
2117 existence of an insolvent workers' compensation insurer, not later than
2118 three days after he receives notice of the determination of any such
2119 insolvency; [(b)] (2) upon request of the board of directors, provide
2120 said association with a statement of the net direct written premiums of
2121 each member insurer.

2122 [(2)] (b) The commissioner may: [(a)] (1) Require that said
2123 association notify those persons insured by the insolvent insurer, and
2124 any other interested parties, of the determination of insolvency and of
2125 their rights under sections 38a-836 to 38a-853, inclusive. Such
2126 notification shall be by mail sent to their last known address, where
2127 available, provided if sufficient information for such notification by
2128 mail is not available, notice by publication in a newspaper of general
2129 circulation shall be sufficient to satisfy the requirements of this
2130 subsection; [(b)] (2) suspend or revoke, after notice and hearing, the
2131 certificate of authority to transact insurance in this state of any member
2132 insurer that fails to pay an assessment when due or which fails to
2133 comply with said plan of operation. In lieu of such suspension or
2134 revocation, the commissioner may levy a fine on any member insurer
2135 which fails to pay an assessment when due, provided no such fine
2136 shall exceed five per cent of the unpaid assessment per month, and
2137 provided no fine shall be less than five hundred dollars per month;
2138 [(c)] (3) revoke the designation of any servicing facility if [he] the
2139 commissioner finds claims are being handled unsatisfactorily.

2140 [(3)] (c) Any person aggrieved by any final action or order of the
2141 commissioner under sections 38a-836 to 38a-853, inclusive, may,
2142 [within] not later than thirty days from the date of such action or
2143 order, petition the superior court for the judicial district of Hartford to
2144 require the commissioner to show cause why said action or order

2145 should not be reversed or eliminated, and, if said court finds that the
2146 action or order of the commissioner was arbitrary and unjustified it
2147 shall take such action in the premises as may seem equitable. The
2148 pendency of any such petitions to show cause shall act as a stay of
2149 execution of any such order. Petitions under this section shall be
2150 privileged in respect of trial assignment.

2151 Sec. 44. Section 38a-844 of the general statutes is repealed and the
2152 following is substituted in lieu thereof (*Effective from passage*):

2153 [(1)] (a) Any person recovering any moneys under sections 38a-836
2154 to 38a-853, inclusive, shall be deemed to have assigned his rights under
2155 the policy to said association to the extent of his recovery from said
2156 association. Every insured or claimant seeking the protection of said
2157 sections shall cooperate with said association to the same extent as
2158 such person would have been required to cooperate with the insolvent
2159 insurer. Said association shall have no cause of action against any
2160 insured of the insolvent insurer for any sums it has paid out to such
2161 insured except such causes of action as the insolvent insurer would
2162 have had if such sums had been paid by the insolvent insurer. In the
2163 case of an insolvent insurer operating on a plan with assessment
2164 liability, payments of claims of said association shall not operate to
2165 reduce the liability of insureds to the receiver, liquidator, or statutory
2166 successor for unpaid assessments.

2167 [(2)] (b) The receiver, liquidator, or statutory successor of an
2168 insolvent insurer shall be bound by determinations of covered claim
2169 eligibility under sections 38a-836 to 38a-853, inclusive, and by
2170 settlements of claims made by said association or any similar
2171 organization having a like function to that of said association in
2172 another state. The court having jurisdiction shall grant such claims
2173 priority equal to that to which the claimant would have been entitled
2174 in the absence of said sections 38a-836 to 38a-853, inclusive, against the
2175 assets of the insolvent insurer. The expenses of said association or any
2176 similar organization having a like function to that of said association in
2177 handling claims shall be accorded the same priority as the receiver's or

2178 liquidator's expenses.

2179 [(3)] (c) Said association shall periodically file with the receiver or
2180 liquidator of the insolvent insurer statements of the covered claims
2181 paid by said association, the expenses paid for the processing of
2182 covered claims paid or contested and estimates of anticipated claims
2183 on said association, and expenses of processing such claims which
2184 shall preserve the rights of said association against the assets of the
2185 insolvent insurer.

2186 [(4) (A)] (d) (1) Except as provided in [subparagraph (B)]
2187 subdivision (2) of this [subdivision] subsection, the association shall
2188 have the right to recover from the following persons the amount of any
2189 covered claim paid on behalf of such person pursuant to sections 38a-
2190 836 to 38a-853, inclusive: [(i)] (A) Any person who is an affiliate of the
2191 insolvent insurer and whose liability obligations to other persons are
2192 satisfied in whole or in part by payments made under this chapter; and
2193 [(ii)] (B) any insured whose net worth on December thirty-first of the
2194 year next preceding the date the insurer becomes an insolvent insurer
2195 exceeds fifty million dollars and whose liability obligations to other
2196 persons are satisfied in whole or in part by payments made under said
2197 sections. For purposes of this subdivision, "insured" does not include a
2198 municipality, as defined in section 7-148, or the Second Injury Fund,
2199 established in section 31-354.

2200 [(B)] (2) The association shall have no right to recover pursuant to
2201 [subparagraph (A)] subdivision (1) of this [subdivision] subsection
2202 from any nonprofit corporation organized to deliver health services
2203 and social services to meet the needs of the elderly, that is incorporated
2204 in this state and qualified as a Section 501(c)(3) organization under the
2205 Internal Revenue Code of 1986, or any subsequent corresponding
2206 internal revenue code of the United States, as amended from time to
2207 time, for any amount of covered claims paid on behalf of such
2208 corporation on or after December 1, 2001, provided the insolvent
2209 insurer was declared insolvent prior to May 27, 2008. Any amounts
2210 recovered by the association prior to May 27, 2008, from any such

2211 nonprofit corporation or affiliate of such nonprofit corporation shall
2212 not be required to be reimbursed to such nonprofit corporation or
2213 affiliate of such nonprofit corporation.

2214 Sec. 45. Section 38a-845 of the general statutes is repealed and the
2215 following is substituted in lieu thereof (*Effective from passage*):

2216 [(1)] (a) Any person having a claim against an insurer under any
2217 provision in an insurance policy, other than a policy of an insolvent
2218 insurer, which is also a covered claim under sections 38a-836 to 38a-
2219 853, inclusive, shall exhaust first his rights under such policy. Any
2220 amount payable on a covered claim under said sections shall be
2221 reduced by the amount recoverable under the claimant's insurance
2222 policy or chapter 568.

2223 [(2)] (b) Any person having a claim which may be recovered under
2224 more than one insurance guaranty association or its equivalent having
2225 a like function to that of said association shall seek recovery first from
2226 the association operating in the area of the residence of the insured
2227 except that [(A)] (1) if it is a first party claim for damage to property
2228 with a permanent location, such person shall seek recovery first from
2229 the association operating in the location of the property, and [(B)] (2) if
2230 it is a workers' compensation claim, such person shall seek recovery
2231 first from the association operating in the area of residence of the
2232 claimant. Any recovery under sections 38a-836 to 38a-853, inclusive,
2233 shall be reduced by the amount recoverable from any other insurance
2234 guaranty association or its equivalent having a like function to that of
2235 said association.

2236 [(3)] (c) Any person having a claim under any governmental
2237 insurance or guaranty program which such claim is also a covered
2238 claim shall be required to first exhaust his rights under such program.
2239 Any amount payable on a covered claim under sections 38a-836 to 38a-
2240 853, inclusive, shall be reduced by any amount recoverable under such
2241 program.

2242 Sec. 46. Subsection (a) of section 38a-916 of the general statutes is

2243 repealed and the following is substituted in lieu thereof (*Effective from*
2244 *passage*):

2245 (a) The commissioner as rehabilitator may appoint one or more
2246 special deputies, who shall have all the powers and responsibilities of
2247 the rehabilitator granted under this section, and notwithstanding any
2248 [contrary] provision of law, including chapters 55a and 67, the
2249 commissioner may employ such counsel, clerks and assistants as
2250 deemed necessary. The compensation of the special deputy, counsel,
2251 clerks and assistants and all expenses of taking possession of the
2252 insurer and of conducting the proceedings shall be fixed by the
2253 commissioner, with the approval of the court and shall be paid out of
2254 the funds or assets of the insurer. The persons appointed under this
2255 section shall serve at the pleasure of the commissioner. The
2256 commissioner, as rehabilitator, may, with the approval of the court,
2257 appoint an advisory committee of policyholders, claimants or other
2258 creditors including guaranty associations should such a committee be
2259 deemed necessary, except that the decision to appoint an advisory
2260 committee shall be at the sole discretion of the commissioner, and the
2261 committee shall serve at the pleasure of the commissioner and shall
2262 serve without compensation and without reimbursement for expenses.
2263 No other committee of any nature shall be appointed by the
2264 commissioner or the court in rehabilitation proceedings conducted
2265 under sections 38a-903 to 38a-961, inclusive.

2266 Sec. 47. Subsection (a) of section 38a-923 of the general statutes is
2267 repealed and the following is substituted in lieu thereof (*Effective from*
2268 *passage*):

2269 (a) The liquidator shall have the power: (1) To appoint a special
2270 deputy to act for [him] such liquidator under sections 38a-903 to 38a-
2271 961, inclusive, and to determine [his] such special deputy's reasonable
2272 compensation. The special deputy shall have all powers of the
2273 liquidator granted by this section. The special deputy shall serve at the
2274 pleasure of the liquidator; (2) to employ employees and agents, legal
2275 counsel, actuaries, accountants, appraisers, consultants and such other

2276 personnel as [he] the liquidator may deem necessary to assist in the
2277 liquidation, notwithstanding any [contrary] provision of law,
2278 including chapters 55a and 67; (3) to fix the reasonable compensation
2279 of employees and agents, legal counsel, actuaries, accountants,
2280 appraisers and consultants with the approval of the court; (4) to pay
2281 reasonable compensation to persons appointed and to defray from the
2282 funds or assets of the insurer all expenses of taking possession of,
2283 conserving, conducting, liquidating, disposing of, or otherwise dealing
2284 with the business and property of the insurer. The liquidator shall
2285 have the power to pay reasonable compensation to such persons on an
2286 interim basis. All such interim payments shall be subject to the
2287 approval of the court upon submission by the liquidator. In the event
2288 that the property of the insurer does not contain sufficient cash or
2289 liquid assets to defray the costs incurred, the commissioner may
2290 advance the costs so incurred out of any appropriation for the
2291 maintenance of the Insurance Department. Any amounts so advanced
2292 for expenses of administration shall be repaid to the commissioner for
2293 the use of the Insurance Department out of the first available moneys
2294 of the insurer; (5) to hold hearings, to subpoena witnesses, to compel
2295 their attendance, to administer oaths, to examine any person under
2296 oath and to compel any person to subscribe to [his] such person's
2297 testimony after it has been correctly reduced to writing, and in
2298 connection therewith to require the production of any books, papers,
2299 records or other documents which [he] the liquidator deems relevant
2300 to the inquiry; (6) to collect all debts and moneys due and claims
2301 belonging to the insurer, wherever located, and for this purpose (A) to
2302 institute timely action in other jurisdictions in order to forestall
2303 garnishment and attachment proceedings against such debts; (B) to do
2304 such other acts as are necessary or expedient to collect, conserve or
2305 protect its assets or property, including the power to sell, compound,
2306 compromise or assign debts for purposes of collection upon such terms
2307 and conditions as [he] the liquidator deems best; and (C) to pursue any
2308 creditor's remedies available to enforce the creditor's claims; (7) to
2309 conduct public and private sales of the property of the insurer; (8) to
2310 use assets of the estate of an insurer under a liquidation order to

2311 transfer policy obligations to a solvent assuming insurer, if the transfer
2312 can be arranged without prejudice to applicable priorities under
2313 section 38a-944; (9) to acquire, hypothecate, encumber, lease, improve,
2314 sell, transfer, abandon or otherwise dispose of or deal with, any
2315 property of the insurer at its market value or upon such terms and
2316 conditions as are fair and reasonable. The liquidator shall also have
2317 power to execute, acknowledge and deliver any and all deeds,
2318 assignments, releases and other instruments necessary or proper to
2319 effectuate any sale of property or other transaction in connection with
2320 the liquidation; (10) to borrow money on the security of the assets in
2321 the insurer's estate or without security and to execute and deliver all
2322 documents necessary to that transaction for the purpose of facilitating
2323 the liquidation. Any such funds borrowed may be repaid as an
2324 administrative expense and have priority over any other claims in class
2325 1 under the priority of distributions; (11) to enter into such contracts as
2326 are necessary to carry out the order to liquidate and to affirm or
2327 disavow any contracts to which the insurer is a party; (12) to continue
2328 to prosecute and to institute in the name of the insurer or in the
2329 liquidator's own name any and all suits and other legal proceedings, in
2330 this state or elsewhere, and to abandon the prosecution of claims [he]
2331 the liquidator deems unprofitable to pursue further. If the insurer is
2332 dissolved pursuant to section 38a-922, the liquidator shall have the
2333 power to apply to any court in this state or elsewhere for leave to
2334 substitute the liquidator for the insurer as plaintiff; (13) to prosecute
2335 any action which may exist on behalf of the creditors, members,
2336 policyholders or shareholders of the insurer against any officer of the
2337 insurer or any other person; (14) to remove any or all records and
2338 property of the insurer to the offices of the commissioner or to such
2339 other place as may be convenient for the purposes of efficient and
2340 orderly execution of the liquidation. Guaranty associations shall have
2341 such reasonable access to the records of the insurer as is necessary for
2342 them to carry out their statutory obligations; (15) to deposit in one or
2343 more banks in this state such sums as are required for meeting current
2344 administration expenses and dividend distributions; (16) to invest all
2345 sums not currently needed, unless the court orders otherwise; (17) to

2346 file any necessary documents for record in the office of any recorder of
2347 deeds or record office in this state or elsewhere where property of the
2348 insurer is located; (18) to assert all defenses available to the insurer as
2349 against third persons, including statutes of limitation, statutes of
2350 frauds and the defense of usury. A waiver of any defense by the
2351 insurer after a petition in liquidation has been filed shall not bind the
2352 liquidator. Whenever a guaranty association or foreign guaranty
2353 association has an obligation to defend any suit, the liquidator shall
2354 give precedence to such obligation and may defend only in the absence
2355 of a defense by such guaranty associations; (19) to exercise and enforce
2356 all the rights, remedies [] and powers of any creditor, shareholder,
2357 policyholder [] or member, including any power to avoid any transfer
2358 or lien that may be given by the general law and that is not included
2359 [with] under sections 38a-928 to 38a-930, inclusive; (20) to intervene in
2360 any proceeding wherever instituted that might lead to the
2361 appointment of a receiver or trustee and to act as the receiver or trustee
2362 whenever the appointment is offered; (21) to enter into agreements
2363 with any receiver or commissioner of any other state relating to the
2364 rehabilitation, liquidation, conservation or dissolution of an insurer
2365 doing business in both states; (22) to exercise all powers conferred
2366 upon receivers by the laws of this state not inconsistent with the
2367 provisions of sections 38a-903 to 38a-961, inclusive; (23) to appoint,
2368 with the approval of the court, an advisory committee of
2369 policyholders, claimants or other creditors including guaranty
2370 associations should such a committee be deemed necessary. The
2371 committee shall serve at the pleasure of the commissioner and the
2372 decision to appoint an advisory committee shall be at the sole
2373 discretion of the commissioner. The committee shall serve without
2374 compensation and without reimbursement for expenses. No other
2375 committee shall be appointed by the commissioner or the court in
2376 liquidation proceedings conducted under sections 38a-903 to 38a-961,
2377 inclusive; and (24) to audit the books and records of all agents of the
2378 insurer insofar as those records relate to the business activities of the
2379 insurer.

2380 Sec. 48. Section 38a-962h of the general statutes is repealed and the

2381 following is substituted in lieu thereof (*Effective from passage*):

2382 Notwithstanding any other provision of law, [to the contrary,] the
2383 commissioner may meet with a supervisor appointed under sections
2384 38a-129, 38a-140 and 38a-962 to 38a-962j, inclusive, and with the
2385 attorney or other representative of the supervisor, without the
2386 presence of any other person, at the time of any proceeding or during
2387 the pendency of any proceeding held under authority of said sections
2388 to carry out the commissioner's duties under said sections or for the
2389 supervisor to carry out his duties under said sections.

2390 Sec. 49. Section 14-64 of the general statutes is repealed and the
2391 following is substituted in lieu thereof (*Effective from passage*):

2392 The commissioner may suspend or revoke the license or licenses of
2393 any licensee or impose a civil penalty of not more than one thousand
2394 dollars for each violation on any licensee or both, when, after notice
2395 and hearing, the commissioner finds that the licensee (1) has violated
2396 any provision of any statute or regulation of any state or any federal
2397 statute or regulation pertaining to its business as a licensee or has
2398 failed to comply with the terms of a final decision and order of any
2399 state department or federal agency concerning any such provision; or
2400 (2) has failed to maintain such records of transactions concerning the
2401 purchase, sale or repair of motor vehicles or major component parts, as
2402 required by such regulations as shall be adopted by the commissioner,
2403 for a period of two years after such purchase, sale or repairs, provided
2404 the records shall include the vehicle identification number and the
2405 name and address of the person from whom each vehicle or part was
2406 purchased and to whom each vehicle or part was sold, if a sale
2407 occurred; or (3) has failed to allow inspection of such records by the
2408 commissioner or the commissioner's representative during normal
2409 business hours, provided written notice stating the purpose of the
2410 inspection is furnished to the licensee, or has failed to allow inspection
2411 of such records by any representative of the Division of State Police
2412 within the Department of Public Safety or any organized local police
2413 department, which inspection may include examination of the

2414 premises to determine the accuracy of such records; or (4) has made a
2415 false statement as to the condition, prior ownership or prior use of any
2416 motor vehicle sold, exchanged, transferred, offered for sale or repaired
2417 if the licensee knew or should have known that such statement was
2418 false; or (5) is not qualified to conduct the licensed business, applying
2419 the standards of section 14-51 and the applicable regulations; or (6) has
2420 violated any provision of sections 42-221 to 42-226, inclusive; or (7) has
2421 failed to fully execute or provide the buyer with (A) an order as
2422 described in section 14-62, (B) the properly assigned certificate of title,
2423 or (C) a temporary transfer or new issue of registration; or (8) has
2424 failed to deliver a motor vehicle free and clear of all liens, unless
2425 written notification is given to the buyer stating such motor vehicle
2426 shall be purchased subject to a lien; or (9) has violated any provision of
2427 sections 14-65f to 14-65j, inclusive, and section 14-65l; or (10) has used
2428 registration number plates issued by the commissioner, in violation of
2429 the provisions and standards set forth in sections 14-59 and 14-60 and
2430 the applicable regulations; or (11) has failed to secure or to account for
2431 or surrender to the commissioner on demand official registration
2432 plates or any other official materials in its custody. In addition to, or in
2433 lieu of, the imposition of any other penalties authorized by this section,
2434 the commissioner may order any such licensee to make restitution to
2435 any aggrieved customer.

2436 Sec. 50. Subsection (a) of section 14-65g of the general statutes is
2437 repealed and the following is substituted in lieu thereof (*Effective from*
2438 *passage*):

2439 (a) A customer may waive his right to the estimate of the costs of
2440 parts and labor required by section 14-65f, only in writing in
2441 accordance with this section. Such a waiver shall include an
2442 authorization to perform reasonable and necessary repairs to remedy
2443 the problems complained of, at a cost not to exceed a fixed dollar
2444 amount. The waiver shall be signed by the customer and the customer
2445 shall be given a fully completed copy of the waiver at the time it is
2446 signed. No repair shop shall use waivers to evade its duties under
2447 sections 14-65e to 14-65j, inclusive, and section 14-65l.

2448 Sec. 51. Section 14-65k of the general statutes is repealed and the
2449 following is substituted in lieu thereof (*Effective from passage*):

2450 (a) The Commissioner of Motor Vehicles may conduct
2451 investigations and hold hearings on any matter under the provisions of
2452 sections 14-51 to 14-65j, inclusive, and section 14-65l. The
2453 commissioner may issue subpoenas, administer oaths, compel
2454 testimony and order the production of books, records and documents.
2455 If any person refuses to appear, to testify or to produce any book,
2456 record, paper or document when so ordered, upon application of the
2457 commissioner, a judge of the Superior Court may make such order as
2458 may be appropriate to aid in the enforcement of this section.

2459 (b) The Attorney General, at the request of the commissioner, is
2460 authorized to apply in the name of the state of Connecticut to the
2461 Superior Court for an order temporarily or permanently restraining
2462 and enjoining any person from violating any provision of sections 14-
2463 51 to 14-65j, inclusive, and section 14-65l.

2464 Sec. 52. Section 20-327b of the 2010 supplement to the general
2465 statutes is repealed and the following is substituted in lieu thereof
2466 (*Effective from passage*):

2467 (a) Except as otherwise provided in this section, each person who
2468 offers residential property in the state for sale, exchange or for lease
2469 with option to buy, shall provide a written residential condition report
2470 to the prospective purchaser at any time prior to the prospective
2471 purchaser's execution of any binder, contract to purchase, option [] or
2472 lease containing a purchase option. A photocopy, duplicate original,
2473 facsimile transmission [] or other exact reproduction or duplicate of
2474 the written residential condition report containing the prospective
2475 purchaser's written receipt shall be attached to any written offer,
2476 binder or contract to purchase. A photocopy, duplicate original,
2477 facsimile transmission or other exact reproduction or duplicate of the
2478 written residential condition report containing the signatures of both
2479 seller and purchaser [] shall be attached to any agreement to purchase
2480 the property.

2481 (b) The following shall be exempt from the provisions of this
2482 section: (1) Any transfer from one or more co-owners solely to one or
2483 more of the co-owners; (2) transfers made to the spouse, mother,
2484 father, brother, sister, child, grandparent or grandchild of the
2485 transferor where no consideration is paid; (3) transfers pursuant to an
2486 order of the court; (4) transfers of newly-constructed residential real
2487 property for which an implied warranty is provided under chapter
2488 827; (5) transfers made by executors, administrators, trustees or
2489 conservators; (6) transfers by the federal government, any political
2490 subdivision thereof or any corporation, institution or quasi-
2491 governmental agency chartered by the federal government; (7)
2492 transfers by deed in lieu of foreclosure; (8) transfers by the state of
2493 Connecticut or any political subdivision thereof; (9) transfers of
2494 property which was the subject of a contract or option entered into
2495 prior to January 1, 1996; and (10) any transfer of property acquired by
2496 a judgment of strict foreclosure or by foreclosure by sale or by a deed
2497 in lieu of foreclosure.

2498 (c) The provisions of this section shall apply only to transfers by
2499 sale, exchange or lease with option to buy, of residential real property
2500 consisting of not less than one nor more than four dwelling units
2501 which shall include cooperatives and condominiums, and shall apply
2502 to all transfers, with or without the assistance of a licensed real estate
2503 broker or salesperson, as defined in section 20-311.

2504 (d) (1) Not later than April 1, 2010, the Commissioner of Consumer
2505 Protection [] shall, by regulations adopted in accordance with the
2506 provisions of chapter 54, prescribe the form of the written residential
2507 disclosure report required by this section and sections 20-327c to 20-
2508 327e, inclusive. The regulations shall provide that the form include
2509 information concerning:

2510 (A) Municipal assessments, including, but not limited to, sewer or
2511 water charges applicable to the property. Such information shall
2512 include: (i) Whether such assessment is in effect and the amount of the
2513 assessment; (ii) whether there is an assessment on the property that

2514 has not been paid, and if so, the amount of the unpaid assessment; and
2515 (iii) to the extent of the seller's knowledge, whether there is reason to
2516 believe that the municipality may impose an assessment in the future;

2517 (B) Leased items on the premises, including, but not limited to,
2518 propane fuel tanks, water heaters, major appliances and alarm
2519 systems; and

2520 (C) (i) Whether the real property is located in a municipally
2521 designated village district or municipally designated historic district or
2522 has been designated on the National Register of Historic Places, and
2523 (ii) a statement that information concerning village districts and
2524 historic districts may be obtained from the municipality's village or
2525 historic district commission, if applicable.

2526 (2) Such form of the written residential disclosure report shall
2527 contain the following:

2528 (A) A certification by the seller in the following form:

2529 "To the extent of the seller's knowledge as a property owner, the
2530 seller acknowledges that the information contained above is true and
2531 accurate for those areas of the property listed. In the event a real estate
2532 broker or salesperson is utilized, the seller authorizes the brokers or
2533 salespersons to provide the above information to prospective buyers,
2534 selling agents or buyers' agents.

T11 (Date) (Seller)

T12 (Date) (Seller)"

2535 (B) A certification by the buyer in the following form:

2536 "The buyer is urged to carefully inspect the property and, if desired,
2537 to have the property inspected by an expert. The buyer understands
2538 that there are areas of the property for which the seller has no
2539 knowledge and that this disclosure statement does not encompass
2540 those areas. The buyer also acknowledges that the buyer has read and

2541 received a signed copy of this statement from the seller or seller's
2542 agent.

T13 (Date) (Seller)

T14 (Date) (Seller)"

2543 (C) A statement concerning the responsibility of real estate brokers
2544 in the following form:

2545 "This report in no way relieves a real estate broker of the broker's
2546 obligation under the provisions of section 20-328-5a of the Regulations
2547 of Connecticut State Agencies to disclose any material facts. Failure to
2548 do so could result in punitive action taken against the broker, such as
2549 fines, suspension or revocation of license."

2550 (D) A statement that any representations made by the seller on the
2551 written residential disclosure report shall not constitute a warranty to
2552 the buyer.

2553 (E) A statement that the written residential disclosure report is not a
2554 substitute for inspections, tests and other methods of determining the
2555 physical condition of property.

2556 (F) Information concerning environmental matters such as lead,
2557 radon, subsurface sewage disposal, flood hazards and, if the residence
2558 is or will be served by well water, as defined in section 21a-150, the
2559 results of any water test performed for volatile organic compounds
2560 and such other topics as the Commissioner of Consumer Protection
2561 may determine would be of interest to a buyer.

2562 (G) A statement that information concerning the residence address
2563 of a person convicted of a crime may be available from law
2564 enforcement agencies or the Department of Public Safety and that the
2565 Department of Public Safety maintains a site on the Internet listing
2566 information about the residence address of persons required to register
2567 under section 54-251, 54-252, 54-253 or 54-254, who have so registered.

2568 (e) On or after January 1, 1996, the Commissioner of Consumer
2569 Protection shall make available the residential disclosure report
2570 prescribed in accordance with the provisions of this section and
2571 sections 20-327c to 20-327e, inclusive, to the Division of Real Estate, all
2572 municipal town clerks, the Connecticut Association of Realtors, Inc.,
2573 and any other person or institution that the commissioner believes
2574 would aid in the dissemination and distribution of such form. The
2575 commissioner shall also cause information concerning such form and
2576 the completion of such form to be disseminated in a manner best
2577 calculated, in the commissioner's judgment, to reach members of the
2578 public, attorneys and real estate licensees.

2579 Sec. 53. Section 29-152n of the general statutes is repealed and the
2580 following is substituted in lieu thereof (*Effective from passage*):

2581 Any person who violates any provision of sections 29-152e to
2582 29-152m, inclusive, [and 38a-660a] shall be guilty of a class D felony.

2583 Sec. 54. Subsection (f) of section 42-103jj of the 2010 supplement to
2584 the general statutes is repealed and the following is substituted in lieu
2585 thereof (*Effective from passage*):

2586 (f) In lieu of physically providing the items listed in subsection (e) of
2587 this section, a developer filing an abbreviated application may provide
2588 a statement or statements certifying that any or all of the items
2589 required by subsection (e) of this section are available to be viewed
2590 electronically, at no cost to the department, through an electronic
2591 registry, web site or other electronic means approved by the
2592 commissioner. The method for accessing [said] such items shall be
2593 clearly disclosed in each such certification.

2594 Sec. 55. Subsection (a) of section 42-103kk of the 2010 supplement to
2595 the general statutes is repealed and the following is substituted in lieu
2596 thereof (*Effective from passage*):

2597 (a) The commissioner may adopt regulations, in accordance with
2598 chapter 54, and prescribe and publish forms necessary to carry out the

2599 provisions of sections 42-103cc to 42-103ddd, inclusive. [The] If, after
2600 notice and hearing, the commissioner determines that a developer or
2601 person subject to sections 42-103cc to 42-103ddd, inclusive, has
2602 materially violated any provision of sections 42-103cc to 42-103ddd,
2603 inclusive, or chapter 735a, the commissioner may (1) suspend or
2604 revoke the registration of, place on probation [,] or reprimand any
2605 person subject to sections 42-103cc to 42-103ddd, inclusive, (2) impose
2606 a civil penalty of not more than five thousand dollars for each violation
2607 of sections 42-103cc to 42-103ddd, inclusive, or (3) take any other
2608 disciplinary action authorized by sections 42-103cc to 42-103ddd,
2609 inclusive. [if, after notice and hearing, the commissioner determines
2610 that a developer or person subject to sections 42-103cc to 42-103ddd,
2611 inclusive, has materially violated any provision of sections 42-103cc to
2612 42-103ddd, inclusive, or chapter 735a.] Nothing in sections 42-103cc to
2613 42-103ddd, inclusive, shall be construed to limit or deny any rights or
2614 remedies provided by law.

2615 Sec. 56. Subdivision (16) of subsection (b) of section 42-103mm of the
2616 2010 supplement to the general statutes is repealed and the following
2617 is substituted in lieu thereof (*Effective from passage*):

2618 (16) A description of any bankruptcy of the developer that is
2619 pending or that has occurred within the past five years, pending civil
2620 or criminal suit, adjudication or disciplinary actions material to the
2621 time share plan of which the developer has knowledge;

2622 Sec. 57. Subdivision (25) of subsection (d) of section 42-103mm of
2623 the 2010 supplement to the general statutes is repealed and the
2624 following is substituted in lieu thereof (*Effective from passage*):

2625 (25) A description of the cancellation provisions and the waiver
2626 prohibition set forth in subsections (a) to (c), inclusive, of section 42-
2627 103pp;

2628 Sec. 58. Subdivision (1) of subsection (c) of section 42-103uu of the
2629 2010 supplement to the general statutes is repealed and the following
2630 is substituted in lieu thereof (*Effective from passage*):

2631 (1) An institutional lender to a developer, for [so] as long as such
 2632 lender holds a mortgage encumbering any interest in or lien against a
 2633 portion of the time share property; or

2634 Sec. 59. Section 42-500 of the 2010 supplement to the general statutes
 2635 is repealed and the following is substituted in lieu thereof (*Effective*
 2636 *from passage, and applicable to commercial leases entered, renewed, modified*
 2637 *or extended on or after the effective date of this section*):

2638 (a) If any insurance is required to be obtained for a lease pursuant to
 2639 subsection (e) of section 42a-2A-305, any such agreement as set forth in
 2640 said subsection shall disclose in a conspicuous manner: (1) Whether
 2641 the insurance is included in the lease for no additional charge; (2) if the
 2642 insurance is not included in the lease or if there is an additional charge
 2643 for obtaining insurance through the lessor, that the lessee may
 2644 purchase the required insurance from an insurer of the lessee's choice,
 2645 subject to the lessor's right to reject that insurer for reasonable cause;
 2646 and (3) that the insurance policies offered by the lessor may duplicate
 2647 coverage already provided by a lessee's personal insurance policies.

2648 (b) If insurance on the leased goods is neither required nor provided
 2649 in such lease or by agreement, the lease [must] shall contain or be
 2650 accompanied by a conspicuous statement in a record substantially as
 2651 follows: "No insurance coverage for the leased goods, or loss of the
 2652 leased goods, is provided under this lease."

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	38a-9(b)(2)
Sec. 2	<i>from passage</i>	38a-25(a)(15)
Sec. 3	<i>from passage</i>	38a-55(b)(3)
Sec. 4	<i>from passage</i>	38a-60(c)
Sec. 5	<i>from passage</i>	38a-91ff(d)
Sec. 6	<i>from passage</i>	38a-91k
Sec. 7	<i>from passage</i>	38a-102(d)
Sec. 8	<i>January 1, 2011</i>	38a-307
Sec. 9	<i>from passage</i>	38a-307a

Sec. 10	<i>from passage</i>	38a-336(a)(2)
Sec. 11	<i>from passage</i>	38a-352
Sec. 12	<i>from passage</i>	38a-433(a)
Sec. 13	<i>from passage</i>	38a-439(e)
Sec. 14	<i>from passage</i>	38a-465a
Sec. 15	<i>from passage</i>	38a-465c(a)
Sec. 16	<i>from passage</i>	38a-465g
Sec. 17	<i>from passage</i>	38a-478c(a)(1)
Sec. 18	<i>from passage</i>	38a-479rr(b)
Sec. 19	<i>from passage</i>	38a-481(b)
Sec. 20	<i>from passage</i>	38a-483(b)(6)
Sec. 21	<i>January 1, 2011</i>	38a-491a
Sec. 22	<i>January 1, 2011</i>	38a-492j
Sec. 23	<i>from passage</i>	38a-495a(f)
Sec. 24	<i>January 1, 2011</i>	38a-500(a)
Sec. 25	<i>January 1, 2011</i>	38a-504
Sec. 26	<i>from passage</i>	38a-511(c)
Sec. 27	<i>from passage</i>	38a-513e
Sec. 28	<i>January 1, 2011</i>	38a-517a(a)
Sec. 29	<i>January 1, 2011</i>	38a-518j
Sec. 30	<i>January 1, 2011</i>	38a-527(a)
Sec. 31	<i>from passage</i>	38a-538
Sec. 32	<i>January 1, 2011</i>	38a-542
Sec. 33	<i>January 1, 2011</i>	38a-546(a)
Sec. 34	<i>from passage</i>	38a-556
Sec. 35	<i>from passage</i>	38a-564(3) and (4)
Sec. 36	<i>from passage</i>	38a-569
Sec. 37	<i>from passage</i>	38a-760a(7)
Sec. 38	<i>from passage</i>	38a-790(d)(2)
Sec. 39	<i>from passage</i>	38a-839
Sec. 40	<i>from passage</i>	38a-840
Sec. 41	<i>from passage</i>	38a-841
Sec. 42	<i>from passage</i>	38a-842
Sec. 43	<i>from passage</i>	38a-843
Sec. 44	<i>from passage</i>	38a-844
Sec. 45	<i>from passage</i>	38a-845
Sec. 46	<i>from passage</i>	38a-916(a)
Sec. 47	<i>from passage</i>	38a-923(a)
Sec. 48	<i>from passage</i>	38a-962h
Sec. 49	<i>from passage</i>	14-64
Sec. 50	<i>from passage</i>	14-65g(a)

Sec. 51	<i>from passage</i>	14-65k
Sec. 52	<i>from passage</i>	20-327b
Sec. 53	<i>from passage</i>	29-152n
Sec. 54	<i>from passage</i>	42-103jj(f)
Sec. 55	<i>from passage</i>	42-103kk(a)
Sec. 56	<i>from passage</i>	42-103mm(b)(16)
Sec. 57	<i>from passage</i>	42-103mm(d)(25)
Sec. 58	<i>from passage</i>	42-103uu(c)(1)
Sec. 59	<i>from passage, and applicable to commercial leases entered, renewed, modified or extended on or after the effective date of this section</i>	42-500

INS *Joint Favorable*

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 11 \$	FY 12 \$
Department of Motor Vehicles	TF - Revenue Gain	Potential Minimal	Potential Minimal
Secretary of the State	GF - Revenue Gain	less than 1,200	less than 1,200

Note: TF=Transportation Fund; GF=General Fund

Municipal Impact: None

Explanation

There is a potential revenue gain to the Transportation Fund of up to \$1,000 due to the expansion of penalties assessed by the Department of Motor Vehicles (DMV) to include violations of motor vehicle shop requirements. The amount of revenue gain will depend on the number of violations.

The bill also requires captive insurers, formed as a reciprocal insurer or limited liability company, to file articles of incorporation with the Secretary of State (SOS). These insurers would incur a one-time filing fee of \$120. It is estimated that a maximum of ten such insurers will file in FY 11 and FY 12, for a maximum revenue gain to the General Fund of \$1,200 in each fiscal year.

Other provisions of the bill are technical and clarifying changes and do not result in a fiscal impact to the state or municipalities.

The Out Years

The fiscal impact identified above for DMV would continue into the future subject to the number of motor vehicle repair shop violations. The fiscal impact identified above for SOS would continue into the

future subject to the number of captive insurance companies, formed as a reciprocal insurer or limited liability company, filing articles of incorporation with SOS.

OLR Bill Analysis**HB 5006*****AN ACT CONCERNING THE LEGISLATIVE COMMISSIONERS' RECOMMENDATIONS FOR TECHNICAL REVISIONS AND 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 requirements;
3. makes 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, not just those formed as a corporation, to file a certificate of general good and articles of incorporation, if applicable, with the secretary of the state;
5. requires captive insurers domiciled outside of Connecticut offering, renewing, or continuing insurance here to submit to the insurance commissioner certain financial statements, risk retention group examination reports, and, upon request, risk retention audits;
6. resolves a statutory conflict within the license expiration and renewal requirements for life settlement producers and brokers;

and

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

EFFECTIVE DATE: Upon passage, except for the provisions extending the applicability of certain insurance benefit requirements and a technical change, which are effective January 1, 2011.

§§ 21-22, 24-25, 28-30, & 32-33 — 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.)

General Anesthesia Relating to Dental Services (§§ 21 & 28)

The bill requires individual and group health insurance policies amended in Connecticut on or after January 1, 2011 to cover medically necessary general anesthesia, nursing, and related hospital services provided to patients with (1) complex dental conditions that require procedures to be performed in a hospital or (2) developmental disabilities that place 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.

Ostomy Appliances and Supplies (§§ 22 & 29)

The bill requires individual and group health insurance policies amended in Connecticut on or after January 1, 2011 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.

Bodily Injury (§§ 24 & 30)

The bill prohibits individual and group health insurance policies continued in Connecticut on or after January 1, 2011 from excluding coverage for a bodily injury solely because it was caused by a work-related accident to a person who is not covered by the Workers' Compensation law. The law already applies to policies delivered, issued, amended, or renewed in Connecticut.

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; (d) accident only coverage; and (e) hospital or medical services, including coverage under an HMO plan and (2) individual health insurance policies that provide limited benefit health coverage.

Treatment of Tumors and Leukemia and Related Benefits (§§ 25 & 32)

The bill requires individual and group health insurance policies renewed, amended, or continued in Connecticut on or after January 1, 2011 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.

Continuation of Coverage (§ 33)

The bill requires group health insurance policies amended in Connecticut on or after January 1, 2011, regardless of the number of insureds, to contain state continuation of coverage (“mini-COBRA”) provisions. The law already requires policies delivered, issued, renewed, or continued in Connecticut to contain those provisions.

Both the bill and current law apply to group health insurance policies that cover (a) basic hospital expenses; (b) basic medical-surgical expenses; (c) hospital confinement indemnity coverage; (d) major medical expenses; and (e) hospital or medical services, including coverage under an HMO plan

§§ 49-51 — MOTOR VEHICLE REPAIR SHOP NOTICE REQUIREMENT

The bill allows the DMV commissioner to impose penalties for violations of the motor vehicle repair shop notice 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 repair shop notice requirements. 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 the notice requirements. He currently has this authority with respect to other motor vehicle dealer and repairer laws. The bill also allows the attorney general, at the 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.

§§ 2, 5, & 6 — CAPTIVE INSURERS

The bill 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 captive's registered office. By law, the commissioner is already the agent for captive insurers domiciled outside of Connecticut that do business here.

The bill requires a captive insurance company formed as a reciprocal insurer or limited liability company 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.

The bill also makes technical and conforming changes in the captive laws.

§§ 14 & 16 — 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 a written notice of nonrenewal by first class mail 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.

§ 18 — 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 to follow when updating its filed list of Connecticut marketers operating under a different name from its own.

§ 27 — PREMIUM PAYMENTS FOR TERMINATED EMPLOYEES

PA 09-126 allows an employer, with certain exceptions, to elect to stop paying group health insurance premiums for an employee and his or her dependents as of 72 hours after the employee quits or is terminated for any reason except layoff. The bill adds another exception: relocation or closing of a "covered establishment" (i.e., an industrial, commercial, or business facility that employs, or has

employed in the preceding 12 months, 100 or more people).

The bill specifies that an employee's or dependent's right to continue coverage after a covered establishment relocates or closes is not affected by PA 09-126. By law, when a covered establishment relocates or closes, the employer must pay for continued insurance coverage for affected employees and dependents for 120 days or until the employee becomes eligible for other coverage (CGS § 31-51o).

§ 53 — 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, a "motor vehicle repair shop" means a new car dealer, a used car dealer, a repairer, or a limited repairer (CGS § 14-65e). No one may operate such a shop without a DMV-issued new car dealer's,

used car dealer's, repairer's, or limited repairer's license (CGS § 14-52).

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

The Insurance and Real Estate Committee favorably reported HB 5009, which includes changes found in §§ 22, 25, 29, and 32 of this bill.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 17 Nay 0 (02/23/2010)