House of Representatives

File No. 546

General Assembly

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House Bill No. 5006
As Amended by House
Amendment Schedule "A"

Approved by the Legislative Commissioner
April 14, 2010

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:

Section 1. Subdivision (2) of subsection (b) of section 38a-9 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(2) The commissioner shall prepare a list of at least ten persons, who have not been employed by the department or an insurance company during the preceding twelve months, to serve as arbitrators in the settlement of such disputes. The arbitrators shall be members of any dispute resolution organization approved by the commissioner. One arbitrator shall be appointed to hear and decide each complaint. Appointment shall be based solely on the order of the list. If an arbitrator is unable to serve on a given day, or if either party objects to the arbitrator, then the next arbitrator on the list **[**will**]** <u>shall</u> be selected. The department shall schedule arbitration hearings as often, and in such locations, as it deems necessary. Parties to the dispute shall be provided written notice of the hearing **[**,**]** at least ten days prior to the

hearing date. The commissioner may issue subpoenas on behalf of the arbitrator to compel the attendance of witnesses and the production of documents, papers and records relevant to the dispute. Decisions shall be made on the basis of the evidence presented at the arbitration hearing. Where the arbitrator believes that technical expertise is necessary to decide a case, [he] such arbitrator may consult with an independent expert recommended by the commissioner. The arbitrator and any independent technical expert shall be paid by the department on a per dispute basis as established by the commissioner. The arbitrator, as expeditiously as possible [,] but not later than fifteen days after the arbitration hearing, shall render a written decision based on the information gathered and disclose the findings and the reasons to the parties involved. The arbitrator shall award filing fees to the prevailing party. If the decision favors the consumer the decision shall provide specific and appropriate remedies including interest at the rate of ten per cent on the arbitration award concerning the disputed amount of the claim, retroactive to the date of payment for the undisputed amount of the claim. The decision may include costs for loss of use and storage of the motor vehicle and shall specify a date for performance and completion of all awarded remedies. Notwithstanding any provision of the general statutes or any regulation, [to the contrary,] the Insurance Department shall not amend, reverse, rescind, or revoke any decision or action of any arbitrator. The department shall contact the consumer [within] not later than ten [working] business days after the date for performance, to determine whether performance has occurred. Either party may make application to the superior court for the judicial district in which one of the parties resides or, when the court is not in session, any judge thereof for an order confirming, vacating, modifying or correcting any award, in accordance with the provisions of sections 52-417, 52-418, 52-419 and 52-420. If it is determined by the court that either party's position after review has been improved by at least ten per cent over that party's position after arbitration, the court [, in its discretion,] may grant to that party its costs and reasonable attorney's fees. No evidence, testimony, findings, or decision from the department

arbitration procedure shall be admissible in any civil proceeding, except judicial review of the arbitrator's decision as contemplated by this subsection.

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

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

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

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

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

(c) If such emergency plan is adopted, it may provide that it will become operative automatically during any such national emergency and, notwithstanding any **[**contrary**]** provision of the law or the charter or bylaws of the company, may contain any provisions reasonably necessary for the operation of the company during any such national emergency. Such provisions need not be consistent with the comparable provisions stated in subsection (b) of this section. Such provisions may provide, among other things, for (1) the designation of

persons who may call a meeting of the board of directors; (2) the quorum and notice requirements for, and location of, any such meeting; (3) the filling of vacancies on the board of directors; (4) a succession list of persons by name or title who will succeed to positions of higher rank; (5) the establishment of the principal office of the company at a new location in or out of the state.

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

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

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

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

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

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

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

(2) Formed as a reciprocal insurer, the organizers shall petition the commissioner to issue a certificate setting forth the commissioner's finding that the establishment and maintenance of the proposed 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-307a of the 2010 supplement to the general
155 statutes is repealed and the following is substituted in lieu thereof
156 (*Effective from passage*):

157 From July 1, 2004, until the expiration of the Terrorism Insurance
158 Program established in the federal Terrorism Risk Insurance Act of
159 2002, P.L. 107-297, as amended from time to time, **[**for**]** (1) for any
160 master policy that is required to be purchased by a condominium
161 association pursuant to section 47-83 or by a unit owners' association
162 pursuant to section 47-255, the standard form of fire insurance policy
163 set forth in section 38a-307, as amended by this act, shall not exclude
164 coverage for loss by fire or other perils insured against in the policy
165 caused, directly or indirectly, by terrorism, as defined by the Insurance
166 Commissioner; and (2) for any other commercial risk insurance policy,
167 the standard form of fire insurance policy set forth in section 38a-307,
168 as amended by this act, may provide that the company shall not be
169 liable for loss by fire or other perils insured against in the policy
170 caused, directly or indirectly, by terrorism, as defined by the Insurance
171 Commissioner, provided the premiums charged for such policy shall
172 reflect any savings projected from the exclusion of such perils.

173 Sec. 9. Subdivision (2) of subsection (a) of section 38a-336 of the
174 general statutes is repealed and the following is substituted in lieu
175 thereof (*Effective from passage*):

(2) Notwithstanding any provision of this section, [to the contrary,] each automobile liability insurance policy issued or renewed on and after January 1, 1994, shall provide uninsured and underinsured motorist coverage with limits for bodily injury and death equal to those purchased to protect against loss resulting from the liability imposed by law unless any named insured requests in writing a lesser amount, but not less than the limits specified in subsection (a) of section 14-112. Such written request shall apply to all subsequent renewals of coverage and to all policies or endorsements [which] that extend, change, supersede or replace an existing policy issued to the named insured, unless changed in writing by any named insured. No such written request for a lesser amount shall be effective unless any named insured has signed an informed consent form [which] that shall contain: (A) An explanation of uninsured and underinsured motorist insurance approved by the commissioner; (B) a list of uninsured and underinsured motorist coverage options available from the insurer; and (C) the premium cost for each of the coverage options available from the insurer. Such informed consent form shall contain a heading in twelve-point type and shall state: "WHEN YOU SIGN THIS FORM, YOU ARE CHOOSING A REDUCED PREMIUM, BUT YOU ARE ALSO CHOOSING NOT TO PURCHASE CERTAIN VALUABLE COVERAGE WHICH PROTECTS YOU AND YOUR FAMILY. IF YOU ARE UNCERTAIN ABOUT HOW THIS DECISION WILL AFFECT YOU, YOU SHOULD GET ADVICE FROM YOUR INSURANCE AGENT OR ANOTHER QUALIFIED ADVISER."

Sec. 10. Section 38a-352 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

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

Sec. 11. Subsection (a) of section 38a-433 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) A domestic life insurance company, including for the purposes of this section all domestic fraternal benefit societies which operate on a legal reserve basis, may establish one or more separate accounts and may allocate thereto amounts, including without limitation proceeds applied under optional modes of settlement or under dividend options, to provide for life insurance or life or period-certain annuities, and benefits incidental thereto, payable in fixed or variable amounts or both, or to accumulate funds which are paid to or held by such company pursuant to section 38a-459, subject to the following: **[**(i)**]** (1) The income, gains and losses, realized or unrealized, from assets allocated to a separate account shall be credited to or charged against the account, without regard to other income, gains or losses of the company; **[**(ii)**]** (2) except as may be provided with respect to reserves for guaranteed benefits and funds referred to in subdivision **[**(iii) hereof**]** (3) of this subsection, amounts allocated to any separate account and accumulations thereon may be invested and reinvested in any class of loans and investments, and such loans and investments shall not be included in applying the limitations provided in sections 38a-102 to 38a-102h, inclusive, as amended by this act; **[**(iii)**]** (3) except with the approval of the commissioner and under such conditions as to investments and other matters as he may prescribe, which shall recognize the guaranteed nature of the benefits provided, reserves for **[**(1)**]** (A) benefits guaranteed as to dollar amount and duration, and **[**(2)**]** (B) funds guaranteed as to principal amount or stated rate of interest shall not be maintained in a separate account; **[**(iv)**]** (4) unless otherwise approved by the commissioner, assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to such separate account, provided, that unless otherwise approved by the commissioner, the portion, if any, of the assets of such separate

account equal to the company's reserve liability with regard to the guaranteed benefits and funds referred to in subdivision [(iii) hereof] (3) of this subsection, shall be valued in accordance with the rules otherwise applicable to the company's assets; [(v)] (5) amounts allocated to a separate account in the exercise of the power granted by this section shall be owned by the company, and the company shall not be, nor hold itself out to be, a trustee with respect to such amounts. If, and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the company may conduct; [(vi)] (6) no sale, exchange or other transfer of assets may be made by a company between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such transfer, whether into or from a separate account, is made [(1)] (A) by a transfer of cash, or [(2)] (B) by a transfer of securities having a readily determinable market value, provided that such transfer of securities is approved by the commissioner. The commissioner may approve other transfers among such accounts if, in his opinion, such transfers would not be inequitable; [(vii)] (7) to the extent such company deems it necessary to comply with any applicable federal or state laws, such company, with respect to any separate account, including without limitation any separate account which is a management investment account or a unit investment trust, may provide for persons having an interest therein appropriate voting and other rights and special procedures for the conduct or the business of such account, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants, and the selection of a committee, the members of which need not be otherwise affiliated with such company, to manage the business of such account. The provisions of this subsection shall apply

notwithstanding any inconsistent provision in the charter of any such domestic life insurance company or in the general statutes.

Sec. 12. Subsection (e) of section 38a-439 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(e) The provisions of this subsection shall apply to all policies issued on or after the compliance date established by subdivision (11) of this subsection. (1) Except as provided in subdivision (7) of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of: (A) The then present value of the future guaranteed benefits provided for by the policy; (B) one per cent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and (C) one hundred twenty-five per cent of the nonforfeiture net level premium as hereinafter defined, provided that in applying the percentage specified in <u>this</u> subparagraph<u>,</u> **[**(C),**]** no nonforfeiture net level premium shall be deemed to exceed four per cent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined; (2) the nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits divided by the present value, at such date of issue, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium becomes due; (3) in the case of policies **[**which**]** <u>that</u>, on a basis

312 guaranteed in the policy, provide for unscheduled changes in benefits
313 or premiums, or [which] that provide an option for changes in benefits
314 or premiums other than a change to a new policy, the adjusted
315 premiums and present values shall initially be calculated on the
316 assumption that future benefits and premiums do not change from
317 those stipulated at the date of issue of the policy. At the time of any
318 such change in the benefits or premiums the future adjusted
319 premiums, nonforfeiture net level premiums and present values shall
320 be recalculated on the assumption that future benefits and premiums
321 do not change from those stipulated by the policy immediately after
322 the change; (4) except as otherwise provided in subdivision (7) of this
323 subsection, the recalculated future adjusted premiums for any such
324 policy shall be the uniform percentage of the respective future
325 premiums specified in the policy for each policy year, excluding
326 amounts payable as extra premiums to cover impairments and special
327 hazards, and also excluding any uniform annual contract charge or
328 policy fee specified in the policy in a statement of the method used in
329 calculating the cash surrender values and paid-up nonforfeiture
330 benefits, that the present value, at the time of change to the newly
331 defined benefits or premiums, of all such future adjusted premiums
332 shall be equal to the excess of (A) the sum of: (i) The then present value
333 of the future guaranteed benefits provided for by the policy and (ii) the
334 additional expense allowance, if any, over (B) the then cash surrender
335 value, if any, or present value of any paid-up nonforfeiture benefit
336 under the policy; (5) the additional expense allowance, at the time of
337 the change to the newly defined benefits or premiums, shall be the
338 sum of (A) one per cent of the excess, if positive, of the average
339 amount of insurance at the beginning of each of the first ten policy
340 years subsequent to the change over the average amount of insurance
341 prior to the change at the beginning of each of the first ten policy years
342 subsequent to the time of the most recent previous change, or, if there
343 has been no previous change, the date of issue of the policy; and (B)
344 one hundred twenty-five per cent of the increase, if positive, in the
345 nonforfeiture net level premium; (6) the recalculated nonforfeiture net
346 level premium shall be equal to the amount obtained by dividing (A)

347 by (B) where (A) equals the sum of (i) the nonforfeiture net level
348 premium applicable prior to the change, multiplied by the present
349 value of an annuity of one per annum payable on each anniversary of
350 the policy on or subsequent to the date of change on which a premium
351 would have become due had the change not occurred, and (ii) the
352 present value of the increase in future guaranteed benefits provided
353 for by the policy, and (B) equals the present value of an annuity of one
354 per annum payable on each anniversary of the policy on or subsequent
355 to the date of change on which a premium becomes due; (7)
356 notwithstanding any other provisions of this subsection, in the case of
357 a policy issued on a substandard basis **[**which**]** that provides reduced
358 graded amounts of insurance so that, in each policy year, such policy
359 has the same tabular mortality cost as an otherwise similar policy
360 issued on the standard basis **[**which**]** that provides higher uniform
361 amounts of insurance, adjusted premiums and present values for such
362 substandard policy may be calculated as if it were issued to provide
363 such higher uniform amounts of insurance on the standard basis; (8)
364 all adjusted premiums and present values referred to in this section
365 shall be calculated: (A) (i) For all policies of ordinary insurance on the
366 basis of the Commissioners' 1980 Standard Ordinary Mortality Table
367 or at the election of the company, for any one or more specified plans
368 of life insurance, on the basis of the Commissioners' 1980 Standard
369 Ordinary Mortality Table with ten-year select mortality factors, or (ii)
370 **[**On**]** on or after January 1, 2005, until January 1, 2009, at the election of
371 the company for any one or more specified plans of life insurance
372 issued on or after January 1, 2004, on the basis of the Commissioners'
373 2001 Standard Ordinary Mortality Table, except that with respect to
374 such plans issued before April 1, 2005, such mortality table shall be
375 used solely for the basis of valuation and nonforfeiture and shall not be
376 used to increase the previously agreed required premium; or (iii) **[**For**]**
377 for all policies issued on or after January 1, 2009, on the basis of the
378 Commissioners' 2001 Standard Ordinary Mortality Table; (B) for all
379 policies of industrial insurance, on the basis of the Commissioners'
380 1961 Standard Industrial Mortality Table; (C) for all policies issued in a
381 particular calendar year, on the basis of a rate of interest not exceeding

382 the nonforfeiture interest rate as defined in this subsection, for policies
383 issued in that calendar year, provided, that: (i) At the option of the
384 company, calculations for all policies issued in a particular calendar
385 year may be made on the basis of a rate of interest not exceeding the
386 nonforfeiture interest rate, as defined in this subsection, for policies
387 issued in the immediately preceding calendar year; (ii) under any paid-
388 up nonforfeiture benefit, including any paid-up dividend additions,
389 any cash surrender value available, whether or not required by
390 subsection (a) of this section, shall be calculated on the basis of the
391 mortality table and rate of interest used in determining the amount of
392 such paid-up nonforfeiture benefit and paid-up dividend additions, if
393 any; (iii) a company may calculate the amount of any guaranteed paid-
394 up nonforfeiture benefit including any paid-up additions under the
395 policy on the basis of an interest rate no lower than that specified in
396 the policy for calculating cash surrender values; (iv) in calculating the
397 present value of any paid-up term insurance with accompanying pure
398 endowment, if any, offered as a nonforfeiture benefit, the rates of
399 mortality assumed may be not more than those shown in the
400 Commissioners' 1980 Extended Term Insurance Table for policies of
401 ordinary insurance and not more than the Commissioners' 1961
402 Industrial Extended Term Insurance Table for policies of industrial
403 insurance; (v) for insurance issued on a substandard basis, the
404 calculation of any such adjusted premiums and present values may be
405 based on appropriate modifications of the aforementioned tables; (vi)
406 any ordinary mortality tables, adopted after 1980 by the National
407 Association of Insurance Commissioners that are approved by
408 regulations adopted by the commissioner, in accordance with the
409 provisions of chapter 54, for use in determining the minimum
410 nonforfeiture standard may be substituted for the Commissioners'
411 1980 Standard Ordinary Mortality Table with or without ten-year
412 select mortality factors or the Commissioners' 1980 Extended Term
413 Insurance Table; (vii) any industrial mortality tables, adopted after
414 1980 by the National Association of Insurance Commissioners that are
415 approved by regulations adopted by the commissioner, in accordance
416 with the provisions of chapter 54, [by the commissioner] for use in

417 determining the minimum nonforfeiture standard may be substituted
418 for the Commissioners' 1961 Standard Industrial Mortality Table or the
419 Commissioners' 1961 Industrial Extended Term Insurance Table; (9)
420 the nonforfeiture interest rate per annum for any policy issued in a
421 particular calendar year shall be equal to one hundred twenty-five per
422 cent of the calendar year statutory valuation interest rate for such
423 policy as defined in the standard valuation law, rounded to the nearest
424 one quarter of one per cent; (10) notwithstanding any provision of the
425 general statutes, [to the contrary,] any refiling of nonforfeiture values
426 or their methods of computation for any previously approved policy
427 form [which] that involves only a change in the interest rate or
428 mortality table used to compute nonforfeiture values shall not require
429 refiling of any other provisions of [that] such policy form; (11) on or
430 after October 1, 1981, but prior to January 1, 1989, any company may
431 file with the commissioner a written notice of its election to comply
432 with the provisions of this subsection on or after a specified date and
433 the provisions of this subsection shall apply to such company on or
434 after such specified date, except that on or after January 1, 2005, but
435 prior to January 1, 2009, any company may file with the commissioner
436 a written notice of its election to comply with the provisions of this
437 subsection on or after a specified date with respect to the
438 Commissioners' 2001 Standard Ordinary Mortality Table and the
439 provisions of this subsection shall apply to such company. The
440 provisions of this subsection shall apply to policies issued by any
441 company on or after January 1, 1989, except that the provisions of this
442 subsection with respect to the Commissioners' 2001 Standard Ordinary
443 Mortality Table shall apply to policies issued by any company on or
444 after January 1, 2009.

445 Sec. 13. Section 38a-465a of the 2010 supplement to the general
446 statutes is repealed and the following is substituted in lieu thereof
447 (*Effective from passage*):

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

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

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

461 (d) Not later than thirty days after the first day of operating as a
462 broker, a life insurance producer shall notify the commissioner that
463 such producer is acting as a broker on a form prescribed by the
464 commissioner, and shall pay a filing fee as specified in section 38a-11.
465 Such notification shall include an acknowledgement by the life
466 insurance producer that such producer shall operate as a broker in
467 accordance with this part.

468 (e) The insurer that issued the policy that is the subject of a life
469 settlement contract shall not be responsible for any act or omission of a
470 broker, provider or purchaser arising out of or in connection with the
471 life settlement transaction, unless the insurer receives compensation
472 for the placement of a life settlement contract from the broker,
473 provider or purchaser in connection with such life settlement contract.

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

480 (g) Any license issued for a provider or broker shall be in force only
481 until the last day of March in each year, but may be renewed by the
482 commissioner without formality other than proper application. The

fees for such licenses shall be assessed annually, as provided in section 38a-11. If such provider or broker fails to timely pay the renewal fee, such license shall be automatically revoked if the license fee is not received by the commissioner not later than the fifth day after the commissioner sends, by first class mail, a written notice of nonrenewal to the principal office of the provider or broker, provided such notice shall only be mailed after said last day of March.

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

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

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

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

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

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

(5) The applicant has provided to the commissioner an antifraud

513 plan that meets the requirements of subsection (i) of section 38a-465j
514 and includes:

515 (A) A description of the procedures for detecting and investigating
516 possible fraudulent acts and procedures for resolving material
517 inconsistencies between medical records and insurance applications;

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

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

522 (D) A written description or chart outlining the arrangement of the
523 antifraud personnel responsible for the investigation and reporting of
524 possible fraudulent insurance acts and investigating unresolved
525 material inconsistencies between medical records and insurance
526 applications.

527 **[**(j)**]** (i) The applicant shall provide to the commissioner such
528 information as the commissioner may require, on forms approved by
529 the commissioner. The commissioner may, at any time, require the
530 applicant to fully disclose the identity of its stockholders, except
531 stockholders owning less than ten per cent of the shares of an applicant
532 whose shares are publicly traded, partners, officers and employees,
533 and the commissioner may deny any application for a license if the
534 commissioner determines that any partner, officer, employee or
535 stockholder thereof who may materially influence the applicant's
536 conduct fails to meet any of the standards set forth in sections 38a-465
537 to 38a-465q, inclusive.

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

543 [(l)] (k) The commissioner shall not issue any license to any
544 nonresident applicant unless a written designation of an agent for
545 service of process is filed and maintained with the commissioner or
546 unless the applicant has filed with the commissioner the applicant's
547 written irrevocable consent that any action against the applicant may
548 be commenced against the applicant by service of process on the
549 commissioner.

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

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

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

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

564 [(q)] (p) An individual licensed as a broker shall complete, on a
565 biennial basis, fifteen hours of training related to life settlements and
566 life settlement transactions, except that a life insurance producer
567 operating as a broker pursuant to this section shall not be subject to the
568 requirements of this subsection. Any person failing to meet the
569 requirements of this subsection shall be subject to the penalties
570 imposed by the commissioner.

571 Sec. 14. Subsection (a) of section 38a-465c of the 2010 supplement to
572 the general statutes is repealed and the following is substituted in lieu
573 thereof (*Effective from passage*):

574 (a) No person shall use any form of life settlement contract or
575 disclosure statement in this state unless such form has been filed with
576 and approved by the commissioner. The commissioner shall
577 disapprove a life settlement contract form or disclosure statement form
578 if the commissioner finds any provision in **[**said**]** such form is
579 unreasonable, contrary to the interests of the public, fails to comply
580 with the provisions of sections 38a-465f, 38a-465g, as amended by this
581 act, and 38a-465n and subsection (b) of section 38a-465k, or is
582 otherwise misleading or unfair to the owner. The commissioner may
583 require the submission of advertising materials.

584 Sec. 15. Section 38a-465g of the general statutes is repealed and the
585 following is substituted in lieu thereof (*Effective from passage*):

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

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

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

597 (b) The insurer shall respond to a request for verification of
598 coverage submitted by a provider, broker or life insurance producer on
599 a form approved by the commissioner not later than thirty calendar
600 days after the date the request was received. The insurer shall
601 complete and issue the verification of coverage or indicate in which
602 respects it is unable to respond. In its response, the insurer shall
603 indicate whether, based on the medical evidence and documents
604 provided, the insurer intends to pursue an investigation regarding the
605 validity of the policy.

606 (c) Prior to or at the time of execution of the settlement contract, the
607 provider shall obtain a witnessed document in which the owner
608 consents to the settlement contract, represents that the owner has a full
609 and complete understanding of the settlement contract, that the owner
610 has a full and complete understanding of the benefits of the policy,
611 acknowledges that the owner is entering into the settlement contract
612 freely and voluntarily and, for persons with a terminal or chronic
613 illness or condition, acknowledges that the insured has a terminal or
614 chronic illness or condition and that the terminal or chronic illness or
615 condition was diagnosed after the life insurance policy was issued.

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

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

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

625 **[**(g)**]** (f) Not later than twenty days after an owner executes the life
626 settlement contract, the provider shall give written notice to the insurer
627 that issued the policy that the policy has become subject to a life
628 settlement contract. The notice shall be accompanied by **[**the
629 documents set forth in subsection (c) of section 38a-465h**]** a copy of the
630 medical records release required under subdivision (2) of subsection
631 (a) of this section and a copy of the insured's application for the life
632 settlement contract.

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

636 **[**(i)**]** (h) Each life settlement contract entered into in this state shall

provide that the owner may rescind the contract not later than fifteen days from the date it is executed by all parties thereto. Such rescission exercised by the owner shall be effective only if both notice of rescission is given to the provider and the owner repays all proceeds and any premiums, loans and loan interest paid by the provider within the rescission period. A failure to provide written notice of the right of rescission shall toll the period of such right until thirty days after the written notice of the right of rescission has been given. If the insured dies during the rescission period, the contract shall be deemed to have been rescinded, subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans and loan interest to the provider.

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

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

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

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

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

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

687 (2) The owner submits independent evidence to the provider that
688 one or more of the following conditions have been met within said
689 two-year period: (A) The owner or insured is terminally ill or
690 chronically ill; (B) the owner or insured disposes of the owner or
691 insured's ownership interests in a closely held corporation, pursuant to
692 the terms of a buyout or other similar agreement in effect at the time
693 the insurance policy was initially issued; (C) the owner's spouse dies;
694 (D) the owner divorces his or her spouse; (E) the owner retires from
695 full-time employment; (F) the owner becomes physically or mentally
696 disabled and a physician determines that the disability prevents the
697 owner from maintaining full-time employment; or (G) a final order,
698 judgment or decree is entered by a court of competent jurisdiction on
699 the application of a creditor of the owner, adjudicating the owner
700 bankrupt or insolvent, or approving a petition seeking reorganization
701 of the owner or appointing a receiver, trustee or liquidator to all or a
702 substantial part of the owner's assets.

703 [(o)] (n) Copies of the independent evidence required by
704 subdivision (2) of subsection [(n)] (m) of this section shall be submitted
705 to the insurer when the provider submits a request to the insurer for
706 verification of coverage. The copies shall be accompanied by a letter of
707 attestation from the provider that the copies are true and correct copies
708 of the documents received by the provider. Nothing in this section
709 shall prohibit an insurer from exercising its right to contest the validity
710 of any policy.

711 [(p)] (o) If, at the time the provider submits a request to the insurer
712 to effect the transfer of the policy to the provider, the provider submits
713 a copy of independent evidence of subparagraph (A) of subdivision (2)
714 of subsection [(n)] (m) of this section, such copy shall be deemed to
715 establish that the settlement contract satisfies the requirements of this
716 section.

717 Sec. 16. Subdivision (1) of subsection (a) of section 38a-478c of the
718 2010 supplement to the general statutes is repealed and the following
719 is substituted in lieu thereof (*Effective from passage*):

720 (1) A report on its quality assurance plan that includes, but is not
721 limited to, information on complaints related to providers and quality
722 of care, on decisions related to patient requests for coverage and on
723 prior authorization statistics. Statistical information shall be submitted
724 in a manner permitting comparison across plans and shall include, but
725 not be limited to: (A) The ratio of the number of complaints received to
726 the number of enrollees; (B) a summary of the complaints received
727 related to providers and delivery of care or services and the action
728 taken on the complaint; (C) the ratio of the number of prior
729 authorizations denied to the number of prior authorizations requested;
730 (D) the number of utilization review determinations made by or on
731 behalf of a managed care organization not to certify an admission,
732 service, procedure or extension of stay, and the denials upheld and
733 reversed on appeal within the managed care organization's utilization
734 review procedure; (E) the percentage of those employers or groups
735 that renew their contracts within the previous twelve months; and (F)

736 notwithstanding the provisions of this subsection, on or before July [1,
737 1998, and annually thereafter] first of each year, all data required by
738 the National Committee for Quality Assurance (NCQA) for its Health
739 Plan Employer Data and Information Set (HEDIS). If an organization
740 does not provide information for the National Committee for Quality
741 Assurance for its Health Plan Employer Data and Information Set, then
742 it shall provide such other equivalent data as the commissioner may
743 require by regulations adopted in accordance with the provisions of
744 chapter 54. The commissioner shall find that the requirements of this
745 subdivision have been met if the managed care plan has received a
746 one-year or higher level of accreditation by the National Committee for
747 Quality Assurance and has submitted the Health Plan Employee Data
748 Information Set data required by subparagraph (F) of this subdivision.

749 Sec. 17. Subsection (b) of section 38a-479rr of the general statutes is
750 repealed and the following is substituted in lieu thereof (*Effective from*
751 *passage*):

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

756 (2) Any change made to the list of authorized marketers, specified in
757 subparagraph (M) of subdivision (2) of subsection (a) of this section,
758 shall be electronically filed with the commissioner. If such change is to
759 add a marketer to a medical discount plan organization's list of
760 authorized marketers, such change shall be electronically filed by such
761 organization prior to the marketer doing business in the state for such
762 organization.

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

766 Sec. 18. Subsection (b) of section 38a-481 of the general statutes is
767 repealed and the following is substituted in lieu thereof (*Effective from*

768 *passage*):

769 (b) No rate filed under the provisions of subsection (a) of this
770 section shall be effective until the expiration of thirty days after it has
771 been filed or unless sooner approved by the commissioner in
772 accordance with regulations adopted pursuant to this subsection. The
773 commissioner shall adopt regulations, in accordance with chapter 54,
774 to prescribe standards to **[**insure**]** ensure that such rates shall not be
775 excessive, inadequate or unfairly discriminatory. The commissioner
776 may disapprove such rate within thirty days after it has been filed if it
777 fails to comply with such standards, except that no rate filed under the
778 provisions of subsection (a) of this section for any Medicare
779 supplement policy shall be effective unless approved in accordance
780 with section 38a-474.

781 Sec. 19. Subdivision (6) of subsection (b) of section 38a-483 of the
782 general statutes is repealed and the following is substituted in lieu
783 thereof (*Effective from passage*):

784 (6) A provision as follows: "RELATION OF EARNINGS TO
785 INSURANCE: If the total monthly amount of loss of time benefits
786 promised for the same loss under all valid loss of time coverage upon
787 the insured, whether payable on a weekly or monthly basis, shall
788 exceed the monthly earnings of the insured at the time disability
789 commenced or his average monthly earnings for the period of two
790 years immediately preceding a disability for which claim is made,
791 whichever is the greater, the insurer will be liable only for such
792 proportionate amount of such benefits under this policy as the amount
793 of such monthly earnings or such average monthly earnings of the
794 insured bears to the total amount of monthly benefits for the same loss
795 under all such coverage upon the insured at the time such disability
796 commences and for the return of such part of the premiums paid
797 during such two years as shall exceed the pro-rata amount of the
798 premiums for the benefits actually paid hereunder; but this shall not
799 operate to reduce the total monthly amount of benefits payable under
800 all such coverage upon the insured below the sum of two hundred

801 dollars or the sum of the monthly benefits specified in such coverages,
802 whichever is the lesser, nor shall it operate to reduce benefits other
803 than those payable for loss of time." The foregoing policy provision
804 may be inserted only in a policy which the insured has the right to
805 continue in force subject to its terms by the timely payment of
806 premiums (1) until at least age fifty, or (2) [,] in the case of a policy
807 issued after age forty-four, for at least five years from its date of issue.
808 The insurer may, at its option, include in this provision a definition of
809 "valid loss of time coverage", approved as to form by the
810 commissioner, which definition shall be limited in subject matter to
811 coverage provided by governmental agencies or by organizations
812 subject to regulation by insurance law or by insurance authorities of
813 this or any other state of the United States or any province of Canada,
814 or to any other coverage the inclusion of which may be approved by
815 the commissioner or any combination of such coverages. In the
816 absence of such definition such term shall not include any coverage
817 provided for such insured pursuant to any compulsory benefit statute,
818 including any workers' compensation or employer's liability statute, or
819 benefits provided by union welfare plans or by employer or employee
820 benefit organizations.

821 Sec. 20. Section 38a-491a of the general statutes is repealed and the
822 following is substituted in lieu thereof (*Effective January 1, 2011*):

823 (a) Each individual health insurance policy providing coverage of
824 the type specified in subdivisions (1), (2), (4), (11) and (12) of section
825 38a-469 delivered, issued for delivery, renewed, amended or continued
826 in this state [on or after January 1, 2000,] shall provide coverage for
827 general anesthesia, nursing and related hospital services provided in
828 conjunction with in-patient, outpatient or one-day dental services if the
829 following conditions are met:

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

834 (2) The patient is either (A) determined by a licensed dentist, in
835 conjunction with a licensed physician who specializes in primary care,
836 to have a dental condition of significant dental complexity that it
837 requires certain dental procedures to be performed in a hospital, or (B)
838 a person who has a developmental disability, as determined by a
839 licensed physician who specializes in primary care, that places the
840 person at serious risk.

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

845 Sec. 21. Section 38a-492j of the general statutes is repealed and the
846 following is substituted in lieu thereof (*Effective January 1, 2011*):

847 Each individual health insurance policy providing coverage of the
848 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
849 469 delivered, issued for delivery, renewed, amended or continued in
850 this state **[**on or after October 1, 2000,**]** that provides coverage for
851 ostomy surgery shall include coverage, up to one thousand dollars
852 annually, for medically necessary appliances and supplies relating to
853 an ostomy including, but not limited to, collection devices, irrigation
854 equipment and supplies, skin barriers and skin protectors. As used in
855 this section, "ostomy" includes colostomy, ileostomy and urostomy.
856 Payments under this section shall not be applied to any policy
857 maximums for durable medical equipment. Nothing in this section
858 shall be deemed to decrease policy benefits in excess of the limits in
859 this section.

860 Sec. 22. Subsection (f) of section 38a-495a of the general statutes is
861 repealed and the following is substituted in lieu thereof (*Effective from*
862 *passage*):

863 (f) Notwithstanding any other provision of law, **[**to the contrary,**]** a
864 Medicare supplement policy or certificate shall not exclude or limit
865 benefits for losses incurred more than six months from the effective

866 date of coverage because it involved a preexisting condition. The
867 policy or certificate shall not define a preexisting condition more
868 restrictively than a condition for which medical advice was given or
869 treatment was recommended by or received from a physician within
870 six months before the effective date of coverage.

871 Sec. 23. Subsection (a) of section 38a-500 of the general statutes is
872 repealed and the following is substituted in lieu thereof (*Effective*
873 *January 1, 2011*):

874 (a) Notwithstanding any other provision of the general statutes, [to
875 the contrary,] no individual health insurance policy providing
876 coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11)
877 and (12) of section 38a-469 delivered, issued for delivery, amended,
878 [or] renewed [on or after October 1, 1984,] <u>or continued</u> in this state
879 may exclude coverage for a bodily injury solely because it was caused
880 by an accident arising out of and in the course of employment to a
881 covered individual who is: (1) A sole proprietor or business partner
882 who is not covered by the provisions of chapter 568 or who accepts the
883 provisions of chapter 568 pursuant to subdivision (10) of section 31-
884 275; or (2) an employee of a corporation and who is a corporate officer,
885 regardless of any election by such individual to be excluded from
886 coverage under chapter 568 pursuant to subparagraph (B)(v) of
887 subdivision (9) of section 31-275. [The provisions of this section shall
888 also apply to all such policies or contracts in this state as of the first
889 anniversary date of such policy or contract on or after October 1, 1984.]
890 The payment of benefits pursuant to this section shall be subject to any
891 policy or contract provisions [which] <u>that</u> apply to a claim not
892 resulting from bodily injury caused by an accident arising out of and
893 in the course of employment.

894 Sec. 24. Section 38a-504 of the general statutes is repealed and the
895 following is substituted in lieu thereof (*Effective January 1, 2011*):

896 (a) Each insurance company, hospital service corporation, medical
897 service corporation, health care center or fraternal benefit society

898 [which] that delivers, [or] issues for delivery, renews, amends or
899 continues in this state individual health insurance policies providing
900 coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and
901 (12) of section 38a-469, shall provide coverage under such policies for
902 the surgical removal of tumors and treatment of leukemia, including
903 outpatient chemotherapy, reconstructive surgery, cost of any
904 nondental prosthesis including any maxillo-facial prosthesis used to
905 replace anatomic structures lost during treatment for head and neck
906 tumors or additional appliances essential for the support of such
907 prosthesis, outpatient chemotherapy following surgical procedure in
908 connection with the treatment of tumors, and a wig if prescribed by a
909 licensed oncologist for a patient who suffers hair loss as a result of
910 chemotherapy. Such benefits shall be subject to the same terms and
911 conditions applicable to all other benefits under such policies.

912 (b) Except as provided in subsection (c) of this section, the coverage
913 required by subsection (a) of this section shall provide at least a yearly
914 benefit of five hundred dollars for the surgical removal of tumors, five
915 hundred dollars for reconstructive surgery, five hundred dollars for
916 outpatient chemotherapy, three hundred fifty dollars for a wig and
917 three hundred dollars for a nondental prosthesis, except that for
918 purposes of the surgical removal of breasts due to tumors the yearly
919 benefit for prosthesis shall be at least three hundred dollars for each
920 breast removed.

921 (c) The coverage required by subsection (a) of this section shall
922 provide benefits for the reasonable costs of reconstructive surgery on
923 each breast on which a mastectomy has been performed, and
924 reconstructive surgery on a nondiseased breast to produce a
925 symmetrical appearance. Such benefits shall be subject to the same
926 terms and conditions applicable to all other benefits under such
927 policies. For the purposes of this subsection, reconstructive surgery
928 includes, but is not limited to, augmentation mammoplasty, reduction
929 mammoplasty and mastopexy.

930 Sec. 25. Subsection (c) of section 38a-511 of the general statutes is

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

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

936 Sec. 26. Section 38a-513e of the 2010 supplement to the general
937 statutes is repealed and the following is substituted in lieu thereof
938 (*Effective from passage*):

939 (a) In the event (1) an employer, as defined in section 31-58,
940 terminates an employee for any reason other than layoff or relocation
941 or closing of a covered establishment, as defined in section 31-51n, or
942 (2) an employee voluntarily terminates employment with an employer,
943 such employer may elect not to pay the premium for such employee
944 and any such employee's dependents under a group health insurance
945 policy after the date of such employee's termination. In the event such
946 employer makes such election, any insurer, health care center, hospital
947 or medical service corporation or fraternal benefit society that issues
948 such group health insurance policy shall credit such employer the
949 amount of any premium paid by such employer with respect to such
950 policy for such employee and such employee's dependents attributable
951 to the period after the date of such employee's termination, provided
952 the employer notifies the insurer, health care center, hospital or
953 medical service corporation or fraternal benefit society that issued such
954 policy and the terminated employee not later than seventy-two hours
955 after the termination. Upon the issuance or renewal of such policy,
956 such insurer, health care center, hospital or medical service
957 corporation or fraternal benefit society shall provide such employer
958 with relevant information related to such employer's election,
959 including a notice that it is the employer's responsibility to remit to the
960 terminated employee such employee's portion of the credited
961 premium. Any such credit shall be applied to the employer's next
962 month's premium. In the event of nonrenewal of such policy, the
963 insurer, health care center, hospital or medical service corporation or

964 fraternal benefit society shall refund such credit to the employer.

965 (b) Notwithstanding the provisions of subsection (a) of this section,
966 (1) any contractual agreement entered into through collective
967 bargaining that requires the employer to pay the premium for an
968 employee under a group health insurance policy after the date of such
969 employee's termination shall supersede the provisions of subsection (a)
970 of this section, and (2) no credit shall be available to an employer for
971 any employee's and employee's dependents' coverage for the seventy-
972 two hours immediately following the termination of such employee.

973 (c) Any right of an employee and his dependents to continuation of
974 coverage following the relocation or closing of a covered
975 establishment, as set forth in section 31-51o, shall not be affected by the
976 provisions of this section.

977 Sec. 27. Subsection (a) of section 38a-517a of the general statutes is
978 repealed and the following is substituted in lieu thereof (*Effective*
979 *January 1, 2011*):

980 (a) Each group health insurance policy providing coverage of the
981 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
982 469 delivered, issued for delivery, renewed, amended or continued in
983 this state **[**on or after January 1, 2000,**]** shall provide coverage for
984 general anesthesia, nursing and related hospital services provided in
985 conjunction with in-patient, outpatient or one-day dental services if the
986 following conditions are met:

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

991 (2) The patient is either (A) determined by a licensed dentist, in
992 conjunction with a licensed physician who specializes in primary care,
993 to have a dental condition of significant dental complexity that it
994 requires certain dental procedures to be performed in a hospital, or (B)

995 a person who has a developmental disability, as determined by a
996 licensed physician who specializes in primary care, that places the
997 person at serious risk.

998 Sec. 28. Section 38a-518j of the general statutes is repealed and the
999 following is substituted in lieu thereof (*Effective January 1, 2011*):

1000 Each group health insurance policy providing coverage of the type
1001 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
1002 delivered, issued for delivery, renewed, amended or continued in this
1003 state [on or after October 1, 2000,] that provides coverage for ostomy
1004 surgery shall include coverage, up to one thousand dollars annually,
1005 for medically necessary appliances and supplies relating to an ostomy
1006 including, but not limited to, collection devices, irrigation equipment
1007 and supplies, skin barriers and skin protectors. As used in this section,
1008 "ostomy" includes colostomy, ileostomy and urostomy. Payments
1009 under this section shall not be applied to any policy maximums for
1010 durable medical equipment. Nothing in this section shall be deemed to
1011 decrease policy benefits in excess of the limits in this section.

1012 Sec. 29. Subsection (a) of section 38a-527 of the general statutes is
1013 repealed and the following is substituted in lieu thereof (*Effective*
1014 *January 1, 2011*):

1015 (a) Notwithstanding any other provision of the general statutes, [to
1016 the contrary,] no group health insurance policy providing coverage of
1017 the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of
1018 section 38a-469 delivered, issued for delivery, amended, [or] renewed
1019 [on or after October 1, 1984,] or continued in this state may exclude
1020 coverage for a bodily injury solely because it was caused by an
1021 accident arising out of and in the course of employment to a covered
1022 individual who is: (1) A sole proprietor or business partner who is not
1023 covered by the provisions of chapter 568 or who accepts the provisions
1024 of said chapter 568 pursuant to subdivision (6) of section 31-275; or (2)
1025 an employee of a corporation and who is a corporate officer, regardless
1026 of any election by such individual to be excluded from coverage under

1027 said chapter 568 pursuant to subparagraph (E) of subdivision (5) of
1028 section 31-275. [The provisions of this section shall also apply to all
1029 such policies in this state as of the first anniversary date of such policy
1030 on or after October 1, 1984.] The payment of benefits pursuant to this
1031 section shall be subject to any policy provisions [which] that apply to a
1032 claim not resulting from bodily injury caused by an accident arising
1033 out of and in the course of employment.

1034 Sec. 30. Section 38a-538 of the general statutes is repealed and the
1035 following is substituted in lieu thereof (*Effective from passage*):

1036 Each employer shall allow individuals to elect to continue coverage
1037 under a group plan pursuant to federal extension requirements
1038 established by the Consolidated Omnibus Budget Reconciliation Act of
1039 1985, [(P.L. 99-272)] P.L. 99-272, as amended from time to time.

1040 Sec. 31. Section 38a-542 of the general statutes is repealed and the
1041 following is substituted in lieu thereof (*Effective January 1, 2011*):

1042 (a) Each insurance company, hospital service corporation, medical
1043 service corporation, health care center or fraternal benefit society
1044 [which] that delivers, [or] issues for delivery, renews, amends or
1045 continues in this state group health insurance policies providing
1046 coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)
1047 of section 38a-469 shall provide coverage under such policies for
1048 treatment of leukemia, including outpatient chemotherapy,
1049 reconstructive surgery, cost of any nondental prosthesis, including any
1050 maxillo-facial prosthesis used to replace anatomic structures lost
1051 during treatment for head and neck tumors or additional appliances
1052 essential for the support of such prosthesis, outpatient chemotherapy
1053 following surgical procedures in connection with the treatment of
1054 tumors, a wig if prescribed by a licensed oncologist for a patient who
1055 suffers hair loss as a result of chemotherapy, and costs of removal of
1056 any breast implant which was implanted on or before July 1, 1994,
1057 without regard to the purpose of such implantation, which removal is
1058 determined to be medically necessary. Such benefits shall be subject to

1059 the same terms and conditions applicable to all other benefits under
1060 such policies.

1061 (b) Except as provided in subsection (c) of this section, the coverage
1062 required by subsection (a) of this section shall provide at least a yearly
1063 benefit of one thousand dollars for the costs of removal of any breast
1064 implant, five hundred dollars for the surgical removal of tumors, five
1065 hundred dollars for reconstructive surgery, five hundred dollars for
1066 outpatient chemotherapy, three hundred fifty dollars for a wig and
1067 three hundred dollars for a nondental prosthesis, except that for
1068 purposes of the surgical removal of breasts due to tumors the yearly
1069 benefit for prosthesis shall be at least three hundred dollars for each
1070 breast removed.

1071 (c) The coverage required by subsection (a) of this section shall
1072 provide benefits for the reasonable costs of reconstructive surgery on
1073 each breast on which a mastectomy has been performed, and
1074 reconstructive surgery on a nondiseased breast to produce a
1075 symmetrical appearance. Such benefits shall be subject to the same
1076 terms and conditions applicable to all other benefits under such
1077 policies. For the purposes of this subsection, reconstructive surgery
1078 includes, but is not limited to, augmentation mammoplasty, reduction
1079 mammoplasty and mastopexy.

1080 Sec. 32. Subsection (a) of section 38a-546 of the general statutes is
1081 repealed and the following is substituted in lieu thereof (*Effective*
1082 *January 1, 2011*):

1083 (a) In order to assure reasonable continuation of coverage and
1084 extension of benefits to the citizens of this state, each group health
1085 insurance policy, regardless of the number of insureds, providing
1086 coverage of the type specified in subdivisions (1), (2), (3), (4), (11) and
1087 (12) of section 38a-469, delivered, issued for delivery, renewed,
1088 amended or continued in this state **[**on or after October 1, 1997,**]** shall,
1089 subject to the provisions of subsection (d), contain those provisions
1090 described in subsections (b) and (d) of section 38a-554.

1091 Sec. 33. Section 38a-556 of the general statutes is repealed and the
1092 following is substituted in lieu thereof (*Effective from passage*):

1093 There is hereby created a nonprofit legal entity to be known as the
1094 Health Reinsurance Association. All insurers, health care centers and
1095 self-insurers doing business in the state, as a condition to their
1096 authority to transact the applicable kinds of health insurance defined
1097 in section 38a-551, shall be members of the association. The association
1098 shall perform its functions under a plan of operation established and
1099 approved under **[**subdivision**]** subsection (a) of this section, and shall
1100 exercise its powers through a board of directors established under this
1101 section.

1102 (a) (1) The board of directors of the association shall be made up of
1103 nine individuals selected by participating members, subject to
1104 approval by the commissioner, two of whom shall be appointed by the
1105 commissioner on or before July 1, 1993, to represent health care
1106 centers. To select the initial board of directors, and to initially organize
1107 the association, the commissioner shall give notice to all members of
1108 the time and place of the organizational meeting. In determining
1109 voting rights at the organizational meeting each member shall be
1110 entitled to vote in person or proxy. The vote shall be a weighted vote
1111 based upon the net health insurance premium derived from this state
1112 in the previous calendar year. If the board of directors is not selected
1113 within sixty days after notice of the organizational meeting, the
1114 commissioner may appoint the initial board. In approving or selecting
1115 members of the board, the commissioner may consider, among other
1116 things, whether all members are fairly represented. Members of the
1117 board may be reimbursed from the moneys of the association for
1118 expenses incurred by them as members, but shall not otherwise be
1119 compensated by the association for their services. (2) The board shall
1120 submit to the commissioner a plan of operation for the association
1121 necessary or suitable to assure the fair, reasonable and equitable
1122 administration of the association. The plan of operation shall become
1123 effective upon approval in writing by the commissioner consistent
1124 with the date on which the coverage under sections 38a-505, 38a-546,

1125 as amended by this act, and 38a-551 to 38a-559, inclusive, must be
1126 made available. The commissioner shall, after notice and hearing,
1127 approve the plan of operation provided such plan is determined to be
1128 suitable to assure the fair, reasonable and equitable administration of
1129 the association, and provides for the sharing of association gains or
1130 losses on an equitable proportionate basis. If the board fails to submit a
1131 suitable plan of operation within one hundred eighty days after its
1132 appointment, or if at any time thereafter the board fails to submit
1133 suitable amendments to the plan, the commissioner shall, after notice
1134 and hearing, adopt and promulgate such reasonable rules as are
1135 necessary or advisable to effectuate the provisions of this section. Such
1136 rules shall continue in force until modified by the commissioner or
1137 superseded by a plan submitted by the board and approved by the
1138 commissioner. The plan of operation shall, in addition to requirements
1139 enumerated in sections 38a-505, 38a-546, as amended by this act, and
1140 38a-551 to 38a-559, inclusive: (A) Establish procedures for the handling
1141 and accounting of assets and moneys of the association; (B) establish
1142 regular times and places for meetings of the board of directors; (C)
1143 establish procedures for records to be kept of all financial transactions,
1144 and for the annual fiscal reporting to the commissioner; (D) establish
1145 procedures whereby selections for the board of directors shall be made
1146 and submitted to the commissioner; (E) establish procedures to amend,
1147 subject to the approval of the commissioner, the plan of operations; (F)
1148 establish procedures for the selection of an [administering carrier]
1149 administrator and set forth the powers and duties of the
1150 [administering carrier] administrator; (G) contain additional
1151 provisions necessary or proper for the execution of the powers and
1152 duties of the association; (H) establish procedures for the
1153 advertisement on behalf of all participating carriers of the general
1154 availability of the comprehensive coverage under sections 38a-505,
1155 38a-546, as amended by this act, and 38a-551 to 38a-559, inclusive; (I)
1156 contain additional provisions necessary for the association to qualify as
1157 an acceptable alternative mechanism in accordance with Section 2744
1158 of the Public Health Service Act, as set forth in the Health Insurance
1159 Portability and Accountability Act of 1996, [(P.L. 104-191)] P.L. 104-

1160 191; and (J) contain additional provisions necessary for the association
1161 to qualify as acceptable coverage in accordance with the Pension
1162 Benefit Guaranty Corporation and Trade Adjustment Assistance
1163 programs of the Trade Act of 2002, [(P.L. 107-210)] P.L. 107-210. The
1164 commissioner may adopt regulations in accordance with the
1165 provisions of chapter 54, to establish criteria for the association to
1166 qualify as an acceptable alternative mechanism.

1167 (b) The association shall have the general powers and authority
1168 granted under the laws of this state to carriers to transact the kinds of
1169 insurance defined under section 38a-551, and in addition thereto, the
1170 specific authority to: (1) Enter into contracts necessary or proper to
1171 carry out the provisions and purposes of sections 38a-505, 38a-546, as
1172 amended by this act, and 38a-551 to 38a-559, inclusive; (2) sue or be
1173 sued, including taking any legal actions necessary or proper for
1174 recovery of any assessments for, on behalf of, or against participating
1175 members; (3) take such legal action as necessary to avoid the payment
1176 of improper claims against the association or the coverage provided by
1177 or through the association; (4) establish, with respect to health
1178 insurance provided by or on behalf of the association, appropriate
1179 rates, scales of rates, rate classifications and rating adjustments, such
1180 rates not to be unreasonable in relation to the coverage provided and
1181 the operational expenses of the association; (5) administer any type of
1182 reinsurance program, for or on behalf of participating members; (6)
1183 pool risks among participating members; (7) issue policies of insurance
1184 on an indemnity or provision of service basis providing the coverage
1185 required by sections 38a-505, 38a-546, as amended by this act, and 38a-
1186 551 to 38a-559, inclusive, in its own name or on behalf of participating
1187 members; (8) administer separate pools, separate accounts or other
1188 plans as deemed appropriate for separate members or groups of
1189 members; (9) operate and administer any combination of plans, pools,
1190 reinsurance arrangements or other mechanisms as deemed appropriate
1191 to best accomplish the fair and equitable operation of the association;
1192 (10) set limits on the amounts of reinsurance [which] that may be
1193 ceded to the association by its members; (11) appoint from among

1194 participating members appropriate legal, actuarial and other
1195 committees as necessary to provide technical assistance in the
1196 operation of the association, policy and other contract design, and any
1197 other function within the authority of the association; and (12) apply
1198 for and accept grants, gifts and bequests of funds from other states,
1199 federal and interstate agencies and independent authorities, private
1200 firms, individuals and foundations for the purpose of carrying out its
1201 responsibilities. Any such funds received shall be deposited in the
1202 General Fund and shall be credited to a separate nonlapsing account
1203 within the General Fund for the Health Reinsurance Association and
1204 may be used by the Health Reinsurance Association in the
1205 performance of its duties.

1206 (c) Every member shall participate in the association in accordance
1207 with the provisions of this **[**subdivision**]** subsection. (1) A participating
1208 member shall determine the particular risks it elects to have written by
1209 or through the association. A member shall designate which of the
1210 following classes of risks it shall underwrite in the state, from which
1211 classes of risk it may elect to reinsure selected risks: (A) Individual,
1212 excluding group conversion; and (B) individual, including group
1213 conversion. (2) No member shall be permitted to select out individual
1214 lives from an employer group to be insured by or through the
1215 association. Members electing to administer risks **[**which**]** that are
1216 insured by or through the association shall comply with the benefit
1217 determination guidelines and the accounting procedures established
1218 by the association. A risk insured by or through the association cannot
1219 be withdrawn by the participating member except in accordance with
1220 the rules established by the association. (3) Rates for coverage issued
1221 by or through the association shall not be excessive, inadequate or
1222 unfairly discriminatory. Separate scales of premium rates based on age
1223 shall apply, but rates shall not be adjusted for area variations in
1224 provider costs. Premium rates shall take into consideration the
1225 substantial extra morbidity and administrative expenses for
1226 association risks, reimbursement or reasonable expenses incurred for
1227 the writing of association risks and the level of rates charged by

1228 insurers for groups of ten lives, provided incurred losses [which] that
1229 result from provision of coverage in accordance with section 38a-537
1230 shall not be considered. In no event shall the rate for a given
1231 classification or group be less than one hundred twenty-five per cent
1232 or more than one hundred fifty per cent of the average rate charged for
1233 that classification with similar characteristics under a policy covering
1234 ten lives. All rates shall be promulgated by the association through an
1235 actuarial committee consisting of five persons who are members of the
1236 American Academy of Actuaries, shall be filed with the commissioner
1237 and may be disapproved within sixty days from the filing thereof if
1238 excessive, inadequate or unfairly discriminatory.

1239 (d) (1) Following the close of each fiscal year, the [administering
1240 carrier] administrator shall determine the net premiums, reinsurance
1241 premiums less administrative expense allowance, the expense of
1242 administration pertaining to the reinsurance operations of the
1243 association and the incurred losses for the year. Any net loss shall be
1244 assessed to all participating members in proportion to their respective
1245 shares of the total health insurance premiums earned in this state
1246 during the calendar year, or with paid losses in the year, coinciding
1247 with or ending during the fiscal year of the association or on any other
1248 equitable basis as may be provided in the plan of operations. For self-
1249 insured members of the association, health insurance premiums
1250 earned shall be established by dividing the amount of paid health
1251 losses for the applicable period by eighty-five per cent. Net gains, if
1252 any, shall be held at interest to offset future losses or allocated to
1253 reduce future premiums. (2) Any net loss to the association
1254 represented by the excess of its actual expenses of administering
1255 policies issued by the association over the applicable expense
1256 allowance shall be separately assessed to those participating members
1257 who do not elect to administer their plans. All assessments shall be on
1258 an equitable formula established by the board. (3) The association shall
1259 conduct periodic audits to assure the general accuracy of the financial
1260 data submitted to the association and the association shall have an
1261 annual audit of its operations by an independent certified public

1262 accountant. The annual audit shall be filed with the commissioner for
1263 his review and the association shall be subject to the provisions of
1264 section 38a-14. (4) For the fiscal year ending December 31, 1993, and
1265 the first quarter of the fiscal year ending December 31, 1994, the
1266 [administering carrier] administrator shall not include health care
1267 centers in assessing any net losses to participating members.

1268 (e) All policy forms issued by or through the association shall
1269 conform in substance to prototype forms developed by the association,
1270 shall in all other respects conform to the requirements of sections 38a-
1271 505, 38a-546, as amended by this act, and 38a-551 to 38a-559, inclusive,
1272 and shall be approved by the commissioner. The commissioner may
1273 disapprove any such form if it contains a provision or provisions
1274 which are unfair or deceptive or which encourage misrepresentation of
1275 the policy.

1276 (f) Unless otherwise permitted by the plan of operation, the
1277 association shall not issue, reissue or continue in force comprehensive
1278 health care plan coverage with respect to any person who is already
1279 covered under an individual or group comprehensive health care plan,
1280 or who is sixty-five years of age or older and eligible for Medicare or
1281 who is not a resident of this state. Coverage provided to a HIPAA or
1282 health care tax credit eligible individual may be terminated to the
1283 extent permitted by HIPAA or the Trade Act of 2002, respectively.

1284 (g) Benefits payable under a comprehensive health care plan
1285 insured by or reinsured through the association shall be paid net of all
1286 other health insurance benefits paid or payable through any other
1287 source, and net of all health insurance coverages provided by or
1288 pursuant to any other state or federal law including Title XVIII of the
1289 Social Security Act, Medicare, but excluding Medicaid.

1290 (h) There shall be no liability on the part of and no cause of action of
1291 any nature shall arise against any carrier or its agents or its employees,
1292 the Health Reinsurance Association or its agents or its employees or
1293 the residual market mechanism established under the provisions of

1294 section 38a-557 or its agents or its employees, or the commissioner or
1295 his representatives for any action taken by them in the performance of
1296 their duties under sections 38a-505, 38a-546, as amended by this act,
1297 and 38a-551 to 38a-559, inclusive. This provision shall not apply to the
1298 obligations of a carrier, a self-insurer, the Health Reinsurance
1299 Association or the residual market mechanism for payment of benefits
1300 provided under a comprehensive health care plan.

1301 Sec. 34. Subdivisions (3) and (4) of section 38a-564 of the general
1302 statutes are repealed and the following is substituted in lieu thereof
1303 (*Effective from passage*):

1304 (3) "Eligible employee" means an employee who works on a full-
1305 time basis, with a normal work week of thirty or more hours and
1306 includes a sole proprietor, a partner of a partnership or an
1307 independent contractor, provided such sole proprietor, partner or
1308 contractor is included as an employee under a health care plan of a
1309 small employer but does not include an employee who works on a
1310 part-time, temporary or substitute basis. "Eligible employee" shall
1311 include any employee who is not actively at work but is covered under
1312 the small employer's health insurance plan pursuant to (A) workers'
1313 compensation, (B) continuation of benefits pursuant to federal
1314 extension requirements established by the Consolidated Omnibus
1315 Budget Reconciliation Act of 1985, **[**(P.L. 99-272)**]** P.L. 99-272, as
1316 amended from time to time, **[**(COBRA)**]** or (C) other applicable laws.
1317 **[**Such employees shall not be counted as eligible employees for the
1318 purposes of subsection (4) of this section.**]**

1319 (4) (A) "Small employer" means any person, firm, corporation,
1320 limited liability company, partnership or association actively engaged
1321 in business or self-employed for at least three consecutive months
1322 who, on at least fifty per cent of its working days during the preceding
1323 twelve months, employed no more than fifty eligible employees, the
1324 majority of whom were employed within the state of Connecticut.
1325 "Small employer" includes a self-employed individual. **[**In**]** For the
1326 purposes of determining the number of eligible employees **[**,

1327 companies which] under this subdivision: (i) Companies that are
1328 affiliated companies, as defined in section 33-840, or [which] that are
1329 eligible to file a combined tax return for purposes of taxation under
1330 chapter 208 shall be considered one employer; [. Eligible employees
1331 shall not include] (ii) employees covered through the employer by
1332 health insurance plans or insurance arrangements issued to or in
1333 accordance with a trust established pursuant to collective bargaining
1334 subject to the federal Labor Management Relations Act shall not be
1335 counted; and (iii) employees who are not actively at work but are
1336 covered under the small employer's health insurance plan pursuant to
1337 workers' compensation, continuation of benefits pursuant to federal
1338 extension requirements established by the Consolidated Omnibus
1339 Budget Reconciliation Act of 1985, P.L. 99-272, as amended from time
1340 to time, or other applicable laws shall not be counted. Except as
1341 otherwise specifically provided, provisions of sections 12-201, 12-211,
1342 12-212a and 38a-564 to 38a-572, inclusive, as amended by this act, that
1343 apply to a small employer shall continue to apply until the plan
1344 anniversary following the date the employer no longer meets the
1345 requirements of this definition.

1346 (B) "Small employer" does not include (i) a municipality procuring
1347 health insurance pursuant to section 5-259, (ii) a private school in this
1348 state procuring health insurance through a health insurance plan or an
1349 insurance arrangement sponsored by an association of such private
1350 schools, (iii) a nonprofit organization procuring health insurance
1351 pursuant to section 5-259, unless the Secretary of the Office of Policy
1352 and Management and the State Comptroller make a request in writing
1353 to the Insurance Commissioner that such nonprofit organization be
1354 deemed a small employer for the purposes of this chapter, (iv) an
1355 association for personal care assistants procuring health insurance
1356 pursuant to section 5-259, or (v) a community action agency procuring
1357 health insurance pursuant to section 5-259.

1358 Sec. 35. Section 38a-569 of the general statutes is repealed and the
1359 following is substituted in lieu thereof (*Effective from passage*):

1360 (a) (1) There is established a nonprofit entity to be known as the
1361 "Connecticut Small Employer Health Reinsurance Pool". All insurers
1362 issuing health insurance in this state and insurance arrangements
1363 providing health plan benefits in this state on and after July 1, 1990,
1364 shall be members of the pool.

1365 (2) On or before July 15, 1990, the commissioner shall give notice to
1366 all insurers and insurance arrangements of the time and place for the
1367 initial organizational meeting, which shall take place by September 1,
1368 1990. The members shall select the initial board, subject to approval by
1369 the commissioner. The board shall consist of at least five and not more
1370 than nine representatives of members. There shall be no more than two
1371 members of the board representing any one insurer or insurance
1372 arrangement. In determining voting rights at the organizational
1373 meeting, each member shall be entitled to vote in person or by proxy.
1374 The vote shall be weighted based upon net health insurance premium
1375 derived from this state in the previous calendar year. To the extent
1376 possible, at least one-third of the members of the board shall be
1377 domestic insurance companies and at least two-thirds of the members
1378 of the board shall be small employer carriers. At least one member of
1379 the board shall be a health care center and at least one member shall be
1380 a small employer carrier with less than one hundred million dollars in
1381 net small employer health insurance premium in this state. The
1382 Insurance Commissioner shall be an ex-officio member of the board.
1383 The net premium amount shall be adjusted by the board periodically
1384 for health care cost inflation. In approving selection of the board, the
1385 commissioner shall assure that all members are fairly represented. The
1386 membership of all boards subsequent to the initial board shall, to the
1387 extent possible, reflect the same distribution of representation as is
1388 described in this subdivision.

1389 (3) If the initial board is not elected at the organizational meeting,
1390 the commissioner shall appoint the initial board within fifteen days of
1391 the organizational meeting.

1392 (4) Within ninety days after the appointment of such initial board,

1393 the board shall submit to the commissioner a plan of operation and
1394 thereafter any amendments thereto necessary or suitable to assure the
1395 fair, reasonable and equitable administration of the pool. The
1396 commissioner shall, after notice and hearing, approve the plan of
1397 operation provided he determines it to be suitable to assure the fair,
1398 reasonable and equitable administration of the pool, and provides for
1399 the sharing of pool gains or losses on an equitable proportionate basis
1400 in accordance with the provisions of subsection (d) of this section. The
1401 plan of operation shall become effective upon approval in writing by
1402 the commissioner consistent with the date on which the coverage
1403 under this section shall be made available. If the board fails to submit a
1404 suitable plan of operation within one hundred eighty days after its
1405 appointment, or at any time thereafter fails to submit suitable
1406 amendments to the plan of operation, the commissioner shall, after
1407 notice and hearing, adopt and promulgate a plan of operation or
1408 amendments, as appropriate. The commissioner shall amend any plan
1409 adopted by him, as necessary, at the time a plan of operation is
1410 submitted by the board and approved by the commissioner.

1411 (5) The plan of operation shall establish procedures for: (A)
1412 Handling and accounting of assets and moneys of the pool, and for an
1413 annual fiscal reporting to the commissioner; (B) filling vacancies on the
1414 board, subject to the approval of the commissioner; (C) selecting an
1415 **[**administering insurer**]** administrator and setting forth the powers and
1416 duties of the **[**administering insurer**]** administrator; (D) reinsuring risks
1417 in accordance with the provisions of this section; (E) collecting
1418 assessments from all members to provide for claims reinsured by the
1419 pool and for administrative expenses incurred or estimated to be
1420 incurred during the period for which the assessment is made; and (F)
1421 any additional matters at the discretion of the board.

1422 (6) The pool shall have the general powers and authority granted
1423 under the laws of Connecticut to insurance companies licensed to
1424 transact health insurance and, in addition thereto, the specific
1425 authority to: (A) Enter into contracts as are necessary or proper to
1426 carry out the provisions and purposes of this section, including the

1427 authority, with the approval of the commissioner, to enter into
1428 contracts with programs of other states for the joint performance of
1429 common functions, or with persons or other organizations for the
1430 performance of administrative functions; (B) sue or be sued, including
1431 taking any legal actions necessary or proper for recovery of any
1432 assessments for, on behalf of, or against members; (C) take such legal
1433 action as necessary to avoid the payment of improper claims against
1434 the pool; (D) define the array of health coverage products for which
1435 reinsurance will be provided, and to issue reinsurance policies, in
1436 accordance with the requirements of this section; (E) establish rules,
1437 conditions and procedures pertaining to the reinsurance of members'
1438 risks by the pool; (F) establish appropriate rates, rate schedules, rate
1439 adjustments, rate classifications and any other actuarial functions
1440 appropriate to the operation of the pool; (G) assess members in
1441 accordance with the provisions of subsection (e) of this section, and to
1442 make advance interim assessments as may be reasonable and
1443 necessary for organizational and interim operating expenses. Any such
1444 interim assessments shall be credited as offsets against any regular
1445 assessments due following the close of the fiscal year; (H) appoint from
1446 among members appropriate legal, actuarial and other committees as
1447 necessary to provide technical assistance in the operation of the pool,
1448 policy and other contract design, and any other function within the
1449 authority of the pool; and (I) borrow money to effect the purposes of
1450 the pool. Any notes or other evidence of indebtedness of the pool not
1451 in default shall be legal investments for insurers and may be carried as
1452 admitted assets.

1453 (b) Any member may reinsure with the pool coverage of an eligible
1454 employee of a small employer, or any dependent of such an employee,
1455 except that no member may reinsure with the pool coverage of an
1456 eligible employee of a small employer, or any dependent of such an
1457 employee, whose premium rates are not subject to section 38a-567
1458 pursuant to subdivision (22) of section 38a-567. Any reinsurance
1459 placed with the pool from the date of the establishment of the pool
1460 regarding the coverage of an eligible employee of a small employer, or

1461 any dependent of such an employee shall be provided as follows:

1462 (1) (A) With respect to a special health care plan or a small employer
1463 health care plan, the pool shall reinsure the level of coverage provided;
1464 (B) with respect to other plans, the pool shall reinsure the level of
1465 coverage provided up to, but not exceeding, the level of coverage
1466 provided in a small employer health care plan or the actuarial
1467 equivalent thereof as defined and authorized by the board; and (C) in
1468 either case, no reinsurance may be provided in any calendar year for a
1469 reinsured employee or dependent until five thousand dollars in benefit
1470 payments have been made for services provided during that calendar
1471 year for that reinsured employee or dependent, which payments
1472 would have been reimbursed through said reinsurance in the absence
1473 of the annual five-thousand-dollar deductible. The amount of the
1474 deductible shall be periodically reviewed by the board and may be
1475 adjusted for appropriate factors as determined by the board;

1476 (2) With respect to eligible employees, and their dependents,
1477 coverage may be reinsured: (A) Within such period of time after the
1478 commencement of their coverage under the plan as may be authorized
1479 by the board, or (B) commencing January 1, 1992, on the first plan
1480 anniversary after the employer's coverage has been in effect with the
1481 small employer carrier for a period of three years, and every third plan
1482 anniversary thereafter, provided, commencing May 1, 1994,
1483 reinsurance pursuant to this subparagraph shall only be permitted
1484 with respect to eligible employees and their dependents of a small
1485 employer which has no more than two eligible employees as of the
1486 applicable anniversary;

1487 (3) Reinsurance coverage may be terminated for each reinsured
1488 employee or dependent on any plan anniversary;

1489 (4) Reinsurance of newborn dependents shall be allowed only if the
1490 mother of any such dependent is reinsured as of the date of birth of
1491 such child, and all newborn dependents of reinsured persons shall be
1492 automatically reinsured as of their date of birth; and

1493 (5) Notwithstanding the provisions of subparagraph (A) of
1494 subdivision (2) of this subsection: (A) Coverage for eligible employees
1495 and their dependents provided under a group policy covering two or
1496 more small employers shall not be eligible for reinsurance when such
1497 coverage is discontinued and replaced by a group policy of another
1498 carrier covering two or more small employers, unless coverage for
1499 such eligible employees or dependents was reinsured by the prior
1500 carrier; and (B) at the time coverage is assumed for such group by a
1501 succeeding carrier, such carrier shall notify the pool of its intention to
1502 provide coverage for such group and shall identify the employees and
1503 dependents whose coverage will continue to be reinsured. The time
1504 limitations for providing such notice shall be established by the pool.

1505 (c) Except as provided in subsection (d) of this section, premium
1506 rates charged for reinsurance by the pool shall be established at the
1507 following percentages of the rate established by the pool for that
1508 classification or group with similar characteristics and coverage:

1509 (1) One hundred fifty per cent, with respect to all of the eligible
1510 employees, and their dependents, of a small employer, all of whose
1511 coverage is reinsured in accordance with subdivision (2) of subsection
1512 (b) of this section; and

1513 (2) Five hundred per cent, with respect to an eligible employee or
1514 dependent who is individually reinsured in accordance with
1515 subdivision (2) of subsection (b) of this section and is not reinsured
1516 with all eligible employees of an employer and their dependents.

1517 (d) Premium rates charged for reinsurance by the pool to a health
1518 care center which is approved by the Secretary of Health and Human
1519 Services as a health maintenance organization pursuant to 42 USC 300
1520 et seq., and as such is subject to requirements that limit the amount of
1521 risk that may be ceded to the pool, may be modified by the board, if
1522 appropriate, to reflect the portion of risk that may be ceded to the pool.

1523 (e) (1) Following the close of each fiscal year, the **[**administering
1524 insurer**]** administrator shall determine the net premiums, the pool

1525 expenses of administration and the incurred losses for the year, taking
1526 into account investment income and other appropriate gains and
1527 losses. For purposes of this section, health insurance premiums earned
1528 by insurance arrangements shall be established by adding paid health
1529 losses and administrative expenses of the insurance arrangement.
1530 Health insurance premiums and benefits paid by a member that are
1531 less than an amount determined by the board to justify the cost of
1532 collection shall not be considered for purposes of determining
1533 assessments. For purposes of this subsection, "net premiums" means
1534 health insurance premiums, less administrative expense allowances.

1535 (2) Any net loss for the year shall be recouped by assessments of
1536 members. (A) Assessments shall first be apportioned by the board
1537 among all members in proportion to their respective shares of the total
1538 health insurance premiums earned in this state from health insurance
1539 plans and insurance arrangements covering small employers during
1540 the calendar year coinciding with or ending during the fiscal year of
1541 the pool, or on any other equitable basis reflecting coverage of small
1542 employers as may be provided in the plan of operations. An
1543 assessment shall be made pursuant to this subparagraph against a
1544 health care center, which is approved by the Secretary of Health and
1545 Human Services as a health maintenance organization pursuant to 42
1546 USC 300e et seq., subject to an assessment adjustment formula adopted
1547 by the board and approved by the commissioner for such health care
1548 centers which recognizes the restrictions imposed on such health care
1549 centers by federal law. Such adjustment formula shall be adopted by
1550 the board and approved by the commissioner prior to the first
1551 anniversary of the pool's operation. (B) If such net loss is not recouped
1552 before assessments totaling five per cent of such premiums from plans
1553 and arrangements covering small employers have been collected,
1554 additional assessments shall be apportioned by the board among all
1555 members in proportion to their respective shares of the total health
1556 insurance premiums earned in this state from other individual and
1557 group plans and arrangements, exclusive of any individual Medicare
1558 supplement policies as defined in section 38a-495 during such calendar

1559 year. (C) Notwithstanding the provisions of this subdivision, the
1560 assessments to any one member under subparagraph (A) or (B) of this
1561 subdivision shall not exceed forty per cent of the total assessment
1562 under each subparagraph for the first fiscal year of the pool's operation
1563 and fifty per cent of the total assessment under each subparagraph for
1564 the second fiscal year. Any amounts abated pursuant to this
1565 subparagraph shall be assessed against the other members in a manner
1566 consistent with the basis for assessments set forth in this subdivision.

1567 (3) If assessments exceed actual losses and administrative expenses
1568 of the pool, the excess shall be held at interest and used by the board to
1569 offset future losses or to reduce pool premiums. As used in this
1570 subsection, "future losses" includes reserves for incurred but not
1571 reported claims.

1572 (4) Each member's proportion of participation in the pool shall be
1573 determined annually by the board based on annual statements and
1574 other reports deemed necessary by the board and filed by the member
1575 with it. Insurance arrangements shall report to the board claims
1576 payments made and administrative expenses incurred in this state on
1577 an annual basis on a form prescribed by the commissioner.

1578 (5) Provision shall be made in the plan of operation for the
1579 imposition of an interest penalty for late payment of assessments.

1580 (6) The board may defer, in whole or in part, the assessment of a
1581 health care center if, in the opinion of the board: (A) Payment of the
1582 assessment would endanger the ability of the health care center to
1583 fulfill its contractual obligations, or (B) in accordance with standards
1584 included in the plan of operation, the health care center has written,
1585 and reinsured in their entirety, a disproportionate number of special
1586 health care plans. In the event an assessment against a health care
1587 center is deferred in whole or in part, the amount by which such
1588 assessment is deferred may be assessed against the other members in a
1589 manner consistent with the basis for assessments set forth in this
1590 subsection. The health care center receiving such deferment shall

remain liable to the pool for the amount deferred. The board may attach appropriate conditions to any such deferment.

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

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

Sec. 36. Subdivision (7) of section 38a-760a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(7) "Reinsurance intermediary-manager" means any person, firm, association or corporation who has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department or underwriting office, and acts as an agent for such reinsurer whether known as a

1623 reinsurance intermediary-manager, manager or other similar term.
1624 Notwithstanding any provision [to the contrary] of the general
1625 statutes, the following persons shall not be considered a reinsurance
1626 intermediary-manager, with respect to such reinsurer, for the purposes
1627 of sections 38a-760 to 38a-760i, inclusive: (A) An employee of the
1628 reinsurer; (B) a United States manager of the United States branch of
1629 an alien reinsurer; (C) an underwriting manager [which] that, pursuant
1630 to contract, manages all or part of the reinsurance operations of the
1631 reinsurer, is under common control with the reinsurer, subject to
1632 sections 38a-129 to 38a-140, inclusive, and whose compensation is not
1633 based on the volume of premiums written; (D) the manager of a group,
1634 association, pool or organization of insurers [which] that engages in
1635 joint underwriting or joint reinsurance and [who are] that is subject to
1636 examination by the insurance commissioner of the state in which the
1637 manager's principal business office is located;

1638 Sec. 37. Subdivision (2) of subsection (d) of section 38a-790 of the
1639 general statutes is repealed and the following is substituted in lieu
1640 thereof (*Effective from passage*):

1641 (2) "Motor vehicle physical damage appraiser" means any person,
1642 partnership, association, limited liability company or corporation
1643 [which] that practices as a business the appraising of damages to
1644 motor vehicles insured under automobile physical damage policies or
1645 on behalf of third party claimants.

1646 Sec. 38. Section 38a-839 of the general statutes is repealed and the
1647 following is substituted in lieu thereof (*Effective from passage*):

1648 There is created a nonprofit unincorporated legal entity to be known
1649 as the Connecticut Insurance Guaranty Association. All insurers
1650 defined as member insurers in subdivision (8) of section 38a-838 shall
1651 be members of said association as a condition of their authority to
1652 transact insurance in this state. Said association shall perform its
1653 functions under a plan of operation established and approved under
1654 section 38a-842, as amended by this act, and shall exercise its powers

1655 through a board of directors established under section 38a-840, as
1656 amended by this act. For the purposes of administration and
1657 assessment, said association shall be divided into three separate
1658 accounts: [(a)] (1) The workers' compensation insurance account; [(b)]
1659 (2) the automobile insurance account; and [(c)] (3) an account for all
1660 other insurance to which sections 38a-836 to 38a-853, inclusive, apply.

1661 Sec. 39. Section 38a-840 of the general statutes is repealed and the
1662 following is substituted in lieu thereof (*Effective from passage*):

1663 [(1)] (a) The board of directors of said association shall consist of not
1664 less than five nor more than nine persons serving terms as established
1665 in the plan of operation under section 38a-842, as amended by this act.
1666 The members of the board of directors shall be selected by member
1667 insurers subject to the approval of the commissioner. Vacancies on the
1668 board shall be filled for the remaining period of the term by a majority
1669 vote of the remaining members, subject to the approval of the
1670 commissioner. If no members are selected within sixty days after
1671 October 1, 1971, the commissioner may appoint the initial members of
1672 the board of directors.

1673 [(2)] (b) In approving selections to said board, the commissioner
1674 shall consider among other things whether all member insurers are
1675 fairly represented.

1676 [(3)] (c) Members of said board shall receive no compensation as
1677 such but shall be reimbursed from the assets of said association for
1678 actual and necessary expenses incurred by them in carrying out their
1679 official duties as members of the board of directors.

1680 Sec. 40. Section 38a-841 of the general statutes is repealed and the
1681 following is substituted in lieu thereof (*Effective from passage*):

1682 [(1)] (a) Said association shall: [(a)] (1) Be obligated to the extent of
1683 the covered claims existing prior to the determination of insolvency
1684 and arising within thirty days after the determination of insolvency, or
1685 before the policy expiration date if less than thirty days after the

1686 determination, or before the insured replaces the policy or causes its
1687 cancellation, if he does so within thirty days of such determination,
1688 provided such obligation shall be limited as follows: [(i)] (A) With
1689 respect to covered claims for unearned premiums, to one-half of the
1690 unearned premium on any policy, subject to a maximum of two
1691 thousand dollars per policy; [(ii)] (B) with respect to covered claims
1692 other than for unearned premiums, such obligation shall include only
1693 that amount of each such claim which is in excess of one hundred
1694 dollars and is less than three hundred thousand dollars for claims
1695 arising under policies of insurers determined to be insolvent prior to
1696 October 1, 2007, and four hundred thousand dollars for claims arising
1697 under policies of insurers determined to be insolvent on or after
1698 October 1, 2007, except that said association shall pay the full amount
1699 of any such claim arising out of a workers' compensation policy,
1700 provided in no event shall [(A) said association be obligated] said
1701 association be obligated (i) to any claimant in an amount in excess of
1702 the obligation of the insolvent insurer under the policy form or
1703 coverage from which the claim arises, or [(B) said association be
1704 obligated] (ii) for any claim filed with the association after the
1705 expiration of two years from the date of the declaration of insolvency
1706 unless such claim arose out of a workers' compensation policy and was
1707 timely filed in accordance with section 31-294c; [(b)] (2) be deemed the
1708 insurer to the extent of its obligations on the covered claims and to
1709 such extent shall have all rights, duties, and obligations of the
1710 insolvent insurer as if the insurer had not become insolvent; [(c)] (3)
1711 allocate claims paid and expenses incurred among the three accounts,
1712 created by section 38a-839, as amended by this act, separately, and
1713 assess member insurers separately [(i)] (A) in respect of each such
1714 account for such amounts as shall be necessary to pay the obligations
1715 of said association under subdivision [(a)] (1) of subsection [(1)] (a) of
1716 this section subsequent to an insolvency; [(ii)] (B) the expenses of
1717 handling covered claims subsequent to an insolvency; [(iii)] (C) the
1718 cost of examinations under section 38a-846; and [(iv)] (D) such other
1719 expenses as are authorized by sections 38a-836 to 38a-853, inclusive.
1720 The assessments of each member insurer shall be in the proportion that

1721 the net direct written premiums of such member insurer for the
1722 calendar year preceding the assessment on the kinds of insurance in
1723 such account bears to the net direct written premiums of all member
1724 insurers for the calendar year preceding the assessment on the kinds of
1725 insurance in such account. Each member insurer shall be notified of its
1726 assessment not later than thirty days before it is due. No member
1727 insurer may be assessed in any year on any account an amount greater
1728 than two per cent of that member insurer's net direct written
1729 premiums for the calendar year preceding the assessment on the kinds
1730 of insurance in said account, provided if, at the time an assessment is
1731 levied on the "all other insurance" account, as defined in subdivision
1732 **[**(c)**]** (3) of section 38a-839, as amended by this act, the board of
1733 directors finds that at least fifty per cent of the total net direct written
1734 premiums of a member insurer and all its affiliates, for the year on
1735 which such assessment is based, were from policies issued or delivered
1736 in Connecticut, on risks located in this state, such member insurer shall
1737 be assessed only on such member insurer's net direct written premium
1738 that is attributable to the kind of insurance that gives rise to each
1739 covered claim. If the maximum assessment, together with the other
1740 assets of said association in any account, does not provide in any one
1741 year in any account an amount sufficient to make all necessary
1742 payments from that account, the funds available may be prorated and
1743 the unpaid portion shall be paid as soon thereafter as funds become
1744 available. Said association may defer, in whole or in part, the
1745 assessment of any member insurer, if the assessment would cause the
1746 member insurer's financial statement to reflect amounts of capital or
1747 surplus less than the minimum amounts required for a certificate of
1748 authority by any jurisdiction in which the member insurer is
1749 authorized to transact insurance provided that during the period of
1750 deferment, no dividends shall be paid to shareholders or
1751 policyholders. Deferred assessments shall be paid when such payment
1752 will not reduce capital or surplus below the minimum amounts
1753 required for a certificate of authority. Such payments shall be refunded
1754 to those insurers receiving greater assessments because of such
1755 deferment or, at the election of the insurer, be credited against future

1756 assessments. Each member insurer serving as a servicing facility may
1757 set off against any assessment, authorized payments made on covered
1758 claims and expenses incurred in the payment of such claims by such
1759 member insurer if they are chargeable to the account in respect of
1760 which the assessment is made; [(d)] (4) investigate claims brought
1761 against said association and adjust, compromise, settle, and pay
1762 covered claims to the extent of said association's obligations, and deny
1763 all other claims. The association shall pay claims in any order it deems
1764 reasonable, including but not limited to, payment in the order of
1765 receipt or by classification. It may review settlements, releases and
1766 judgments to which the insolvent insurer or its insureds were parties
1767 to determine the extent to which such settlements, releases and
1768 judgments may be properly contested; [(e)] (5) notify such persons as
1769 the commissioner may direct under subdivision [(a)] (1) of subsection
1770 [(2)] (b) of section 38a-843, as amended by this act; [(f)] (6) handle
1771 claims through its employees or through one or more insurers or other
1772 persons designated by said association as servicing facilities, provided
1773 such designation of a servicing facility shall be subject to the approval
1774 of the commissioner, and may be declined by a member insurer; [(g)]
1775 (7) reimburse each such servicing facility for obligations of said
1776 association paid by such facility and for expenses incurred by such
1777 facility while handling claims on behalf of said association and shall
1778 pay such other expenses of said association as are authorized by
1779 sections 38a-836 to 38a-853, inclusive.

1780 [(2)] (b) Said association may: [(a)] (1) Employ or retain such persons
1781 as are necessary to handle claims and perform other duties of said
1782 association; [(b)] (2) borrow such funds as may be necessary from time
1783 to time to effect the purposes of sections 38a-836 to 38a-853, inclusive,
1784 in accord with the plan of operation under section 38a-842, as
1785 amended by this act; [(c)] (3) sue or be sued; [(d)] (4) intervene as a
1786 matter of right as a party in any proceeding before any court in this
1787 state that has jurisdiction over an insolvent insurer, as defined in
1788 section 38a-838; [(e)] (5) negotiate and become a party to such contracts
1789 as are necessary to carry out the purpose of said sections; [(f)] (6)

1790 perform such other acts as are necessary or proper to effectuate the
1791 purpose of said sections; [(g)] (7) refund to the member insurers in
1792 proportion to the contribution of each such member insurer to that
1793 account, that amount by which the assets of the account exceed the
1794 liabilities, if, at the end of any calendar year, the board of directors
1795 finds that the assets of said association in any account exceed the
1796 liabilities of that account as estimated by the board of directors for the
1797 coming year.

1798 [(3) (A)] (c) (1) Each insurer paying an assessment under sections
1799 38a-836 to 38a-853, inclusive, may offset one hundred per cent of the
1800 amount of such assessment against its premium tax liability to this
1801 state under chapter 207. Such offset shall be taken over a period of the
1802 five successive tax years following the year of payment of the
1803 assessment, at the rate of twenty per cent per year of the assessment
1804 paid to the association. Each insurer to which has been refunded by the
1805 association, pursuant to [subdivision (2)] subsection (b) of this section,
1806 all or a portion of an assessment previously paid to the association by
1807 the insurer shall be required to pay to the Department of Revenue
1808 Services an amount equal to the total amount that has been claimed as
1809 an offset against the premiums tax liability on the premiums tax return
1810 or returns, as the case may be, filed by such insurer and that is
1811 attributable to such refunded assessment, provided the amount
1812 required to be paid to said department shall not exceed the amount of
1813 the refunded assessment. If the amount of the refunded assessment
1814 exceeds the total amount that has been claimed as an offset against the
1815 premiums tax liability on the premiums tax return or returns filed by
1816 such insurer and that is attributable to such refunded assessment, such
1817 excess may not be claimed as an offset against the premiums tax
1818 liability on a premiums tax return or returns filed by such insurer or, if
1819 the offset has been transferred to another person pursuant to
1820 [subparagraph (B)] subdivision (2) of this [subdivision] subsection, by
1821 such other person. For purposes of this subparagraph, if the offset has
1822 been transferred to another person pursuant to [subparagraph (B)]
1823 subdivision (2) of this [subdivision] subsection, the total amount that

1824 has been claimed as an offset against the premiums tax liability on the
1825 premiums tax return or returns filed by such insurer includes the total
1826 amount that has been claimed as an offset against the premiums tax
1827 liability on the premiums tax return or returns filed by such other
1828 person. The association shall promptly notify the Commissioner of
1829 Revenue Services of the name and address of the insurers to which
1830 such refunds have been made, the amount of such refunds and the
1831 date on which such refunds were mailed to such insurer. If the amount
1832 that an insurer is required to pay to the Department of Revenue
1833 Services has not been so paid on or before the forty-fifth day after the
1834 date of mailing of such refunds, the insurer shall be liable for interest
1835 on such amount at the rate of one per cent per month or fraction
1836 thereof from such forty-fifth day to the date of payment.

1837 **[**(B)**]** (2) An insurer, in this subparagraph called "the transferor",
1838 may transfer any offset provided under **[**subparagraph (A)**]**
1839 subdivision (1) of this **[**subdivision**]** subsection to an affiliate, as
1840 defined in section 38a-1, of the transferor. Any such transfer of the
1841 offset by the transferor and any subsequent transfer or transfers of the
1842 same offset shall not affect the obligation of the transferor to pay to the
1843 Department of Revenue Services any sums which are acquired by
1844 refund from the association pursuant to **[**subdivision (2)**]** subsection (b)
1845 of this section and which are required to be paid to the Department of
1846 Revenue Services pursuant to **[**subparagraph (A)**]** subdivision (1) of
1847 this **[**subdivision**]** subsection. Such offset may be taken by any
1848 transferee only against the transferee's premium tax liability to this
1849 state under chapter 207. The Commissioner of Revenue Services shall
1850 not allow such offset to a transferee against its premium tax liability
1851 unless the transferor, the affiliate to which the offset was originally
1852 transferred, each subsequent transferor and each subsequent transferee
1853 have filed such information as may be required on forms provided by
1854 said commissioner with respect to any such transfer or transfers on or
1855 before the due date of the premium tax return on which such offset
1856 would have been taken by the transferor if no transfer had been made
1857 by the transferor.

1858 Sec. 41. Section 38a-842 of the general statutes is repealed and the
1859 following is substituted in lieu thereof (*Effective from passage*):

1860 **[**(1)**]** (a) (1) Said association shall submit to the commissioner a plan
1861 of operation and any amendments thereto necessary or suitable to
1862 assure the fair, reasonable, and equitable administration of said
1863 association. The plan of operation and any amendments thereto shall
1864 become effective upon approval in writing by the commissioner.

1865 **[**(b)**]** (2) If said association fails to submit a suitable plan of operation
1866 within ninety days following October 1, 1971, or if at any time
1867 thereafter said association fails to submit suitable amendments to the
1868 plan, the commissioner shall, after notice and hearing, adopt and
1869 promulgate such reasonable regulations as are necessary or advisable
1870 to effectuate the provisions of sections 38a-836 to 38a-853, inclusive.
1871 Such regulations shall continue in force until modified by the
1872 commissioner or superseded by a plan submitted by said association
1873 and approved by the commissioner.

1874 **[**(2)**]** (b) All member insurers shall comply with the plan of
1875 operation.

1876 **[**(3)**]** (c) The plan of operation shall: **[**(a)**]** (1) Establish the procedures
1877 whereby all the powers and duties of said association under section
1878 38a-841, as amended by this act, shall be performed; **[**(b)**]** (2) establish
1879 procedures for handling the assets of said association; **[**(c)**]** (3) establish
1880 the number, the terms of office and the amount and method of
1881 reimbursing members of the board of directors under section 38a-840,
1882 as amended by this act; **[**(d)**]** (4) establish procedures by which claims
1883 may be filed with said association and establish acceptable forms of
1884 proof of covered claims. Notice of claims to the receiver or liquidator
1885 of the insolvent insurer shall be deemed notice to said association or its
1886 agent and a list of such claims shall be periodically submitted to said
1887 association or similar organization having a like function to that of said
1888 association in another state by the receiver or liquidator; **[**(e)**]** (5)
1889 establish regular places and times for meetings of the board of

1890 directors; [(f)] (6) establish procedures for records to be kept of all
1891 financial transactions of said association, its agents, and the board of
1892 directors; [(g)] (7) provide that any member insurer aggrieved by any
1893 final action or decision of said association may appeal to the
1894 commissioner within thirty days after such action or decision; [(h)] (8)
1895 establish the procedures whereby selections for the board of directors
1896 shall be submitted to the commissioner; [(i)] (9) contain such additional
1897 provisions as may be necessary or proper for the execution of the
1898 powers and duties of said association under sections 38a-836 to 38a-
1899 853, inclusive.

1900 [(4)] (d) The plan of operation may delegate any or all powers and
1901 duties of said association, except those under subdivision [(c)] (3) of
1902 subsection [(1)] (a) of section 38a-841, as amended by this act, and
1903 subdivision [(b)] (2) of subsection [(2)] (b) of section 38a-841, as
1904 amended by this act, to a corporation, association, or other
1905 organization which performs or will perform functions similar to those
1906 of said association, or its equivalent having a like function to that of
1907 said association, in two or more states. Such a corporation, association
1908 or organization shall be reimbursed by said association as a servicing
1909 facility would be reimbursed and shall be paid by said association for
1910 its performance of any other functions of said association. Any
1911 delegation under this subsection shall take effect only with the
1912 approval of both the board of directors and the commissioner, and
1913 may be made only to a corporation, association, or organization which
1914 extends protection not substantially less favorable and effective than
1915 that provided by sections 38a-836 to 38a-853, inclusive.

1916 Sec. 42. Section 38a-843 of the general statutes is repealed and the
1917 following is substituted in lieu thereof (*Effective from passage*):

1918 [(1)] (a) The commissioner shall: [(a)] (1) Notify said association of
1919 the existence of an insolvent insurer, and notify the chairman of the
1920 Workers' Compensation Commission and the State Treasurer of the
1921 existence of an insolvent workers' compensation insurer, not later than
1922 three days after he receives notice of the determination of any such

1923 insolvency; [(b)] (2) upon request of the board of directors, provide
1924 said association with a statement of the net direct written premiums of
1925 each member insurer.

1926 [(2)] (b) The commissioner may: [(a)] (1) Require that said
1927 association notify those persons insured by the insolvent insurer, and
1928 any other interested parties, of the determination of insolvency and of
1929 their rights under sections 38a-836 to 38a-853, inclusive. Such
1930 notification shall be by mail sent to their last known address, where
1931 available, provided if sufficient information for such notification by
1932 mail is not available, notice by publication in a newspaper of general
1933 circulation shall be sufficient to satisfy the requirements of this
1934 subsection; [(b)] (2) suspend or revoke, after notice and hearing, the
1935 certificate of authority to transact insurance in this state of any member
1936 insurer that fails to pay an assessment when due or which fails to
1937 comply with said plan of operation. In lieu of such suspension or
1938 revocation, the commissioner may levy a fine on any member insurer
1939 which fails to pay an assessment when due, provided no such fine
1940 shall exceed five per cent of the unpaid assessment per month, and
1941 provided no fine shall be less than five hundred dollars per month;
1942 [(c)] (3) revoke the designation of any servicing facility if [he] the
1943 commissioner finds claims are being handled unsatisfactorily.

1944 [(3)] (c) Any person aggrieved by any final action or order of the
1945 commissioner under sections 38a-836 to 38a-853, inclusive, may,
1946 [within] not later than thirty days from the date of such action or
1947 order, petition the superior court for the judicial district of Hartford to
1948 require the commissioner to show cause why said action or order
1949 should not be reversed or eliminated, and, if said court finds that the
1950 action or order of the commissioner was arbitrary and unjustified it
1951 shall take such action in the premises as may seem equitable. The
1952 pendency of any such petitions to show cause shall act as a stay of
1953 execution of any such order. Petitions under this section shall be
1954 privileged in respect of trial assignment.

1955 Sec. 43. Section 38a-844 of the general statutes is repealed and the

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

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

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

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

1989 insolvent insurer.

1990 [(4) (A)] (d) (1) Except as provided in [subparagraph (B)]
1991 subdivision (2) of this [subdivision] subsection, the association shall
1992 have the right to recover from the following persons the amount of any
1993 covered claim paid on behalf of such person pursuant to sections 38a-
1994 836 to 38a-853, inclusive: [(i)] (A) Any person who is an affiliate of the
1995 insolvent insurer and whose liability obligations to other persons are
1996 satisfied in whole or in part by payments made under this chapter; and
1997 [(ii)] (B) any insured whose net worth on December thirty-first of the
1998 year next preceding the date the insurer becomes an insolvent insurer
1999 exceeds fifty million dollars and whose liability obligations to other
2000 persons are satisfied in whole or in part by payments made under said
2001 sections. For purposes of this subdivision, "insured" does not include a
2002 municipality, as defined in section 7-148, or the Second Injury Fund,
2003 established in section 31-354.

2004 [(B)] (2) The association shall have no right to recover pursuant to
2005 [subparagraph (A)] subdivision (1) of this [subdivision] subsection
2006 from any nonprofit corporation organized to deliver health services
2007 and social services to meet the needs of the elderly, that is incorporated
2008 in this state and qualified as a Section 501(c)(3) organization under the
2009 Internal Revenue Code of 1986, or any subsequent corresponding
2010 internal revenue code of the United States, as amended from time to
2011 time, for any amount of covered claims paid on behalf of such
2012 corporation on or after December 1, 2001, provided the insolvent
2013 insurer was declared insolvent prior to May 27, 2008. Any amounts
2014 recovered by the association prior to May 27, 2008, from any such
2015 nonprofit corporation or affiliate of such nonprofit corporation shall
2016 not be required to be reimbursed to such nonprofit corporation or
2017 affiliate of such nonprofit corporation.

2018 Sec. 44. Section 38a-845 of the general statutes is repealed and the
2019 following is substituted in lieu thereof (*Effective from passage*):

2020 [(1)] (a) Any person having a claim against an insurer under any

2021 provision in an insurance policy, other than a policy of an insolvent
2022 insurer, which is also a covered claim under sections 38a-836 to 38a-
2023 853, inclusive, shall exhaust first his rights under such policy. Any
2024 amount payable on a covered claim under said sections shall be
2025 reduced by the amount recoverable under the claimant's insurance
2026 policy or chapter 568.

2027 **[**(2)**]** (b) Any person having a claim which may be recovered under
2028 more than one insurance guaranty association or its equivalent having
2029 a like function to that of said association shall seek recovery first from
2030 the association operating in the area of the residence of the insured
2031 except that **[**(A)**]** (1) if it is a first party claim for damage to property
2032 with a permanent location, such person shall seek recovery first from
2033 the association operating in the location of the property, and **[**(B)**]** (2) if
2034 it is a workers' compensation claim, such person shall seek recovery
2035 first from the association operating in the area of residence of the
2036 claimant. Any recovery under sections 38a-836 to 38a-853, inclusive,
2037 shall be reduced by the amount recoverable from any other insurance
2038 guaranty association or its equivalent having a like function to that of
2039 said association.

2040 **[**(3)**]** (c) Any person having a claim under any governmental
2041 insurance or guaranty program which such claim is also a covered
2042 claim shall be required to first exhaust his rights under such program.
2043 Any amount payable on a covered claim under sections 38a-836 to 38a-
2044 853, inclusive, shall be reduced by any amount recoverable under such
2045 program.

2046 Sec. 45. Subsection (a) of section 38a-916 of the general statutes is
2047 repealed and the following is substituted in lieu thereof (*Effective from*
2048 *passage*):

2049 (a) The commissioner as rehabilitator may appoint one or more
2050 special deputies, who shall have all the powers and responsibilities of
2051 the rehabilitator granted under this section, and notwithstanding any
2052 **[**contrary**]** provision of law, including chapters 55a and 67, the

2053 commissioner may employ such counsel, clerks and assistants as
2054 deemed necessary. The compensation of the special deputy, counsel,
2055 clerks and assistants and all expenses of taking possession of the
2056 insurer and of conducting the proceedings shall be fixed by the
2057 commissioner, with the approval of the court and shall be paid out of
2058 the funds or assets of the insurer. The persons appointed under this
2059 section shall serve at the pleasure of the commissioner. The
2060 commissioner, as rehabilitator, may, with the approval of the court,
2061 appoint an advisory committee of policyholders, claimants or other
2062 creditors including guaranty associations should such a committee be
2063 deemed necessary, except that the decision to appoint an advisory
2064 committee shall be at the sole discretion of the commissioner, and the
2065 committee shall serve at the pleasure of the commissioner and shall
2066 serve without compensation and without reimbursement for expenses.
2067 No other committee of any nature shall be appointed by the
2068 commissioner or the court in rehabilitation proceedings conducted
2069 under sections 38a-903 to 38a-961, inclusive.

2070 Sec. 46. Subsection (a) of section 38a-923 of the general statutes is
2071 repealed and the following is substituted in lieu thereof (*Effective from*
2072 *passage*):

2073 (a) The liquidator shall have the power: (1) To appoint a special
2074 deputy to act for **[**him**]** <u>such liquidator</u> under sections 38a-903 to 38a-
2075 961, inclusive, and to determine **[**his**]** <u>such special deputy's</u> reasonable
2076 compensation. The special deputy shall have all powers of the
2077 liquidator granted by this section. The special deputy shall serve at the
2078 pleasure of the liquidator; (2) to employ employees and agents, legal
2079 counsel, actuaries, accountants, appraisers, consultants and such other
2080 personnel as **[**he**]** <u>the liquidator</u> may deem necessary to assist in the
2081 liquidation, notwithstanding any **[**contrary**]** provision of law,
2082 including chapters 55a and 67; (3) to fix the reasonable compensation
2083 of employees and agents, legal counsel, actuaries, accountants,
2084 appraisers and consultants with the approval of the court; (4) to pay
2085 reasonable compensation to persons appointed and to defray from the
2086 funds or assets of the insurer all expenses of taking possession of,

2087 conserving, conducting, liquidating, disposing of, or otherwise dealing
2088 with the business and property of the insurer. The liquidator shall
2089 have the power to pay reasonable compensation to such persons on an
2090 interim basis. All such interim payments shall be subject to the
2091 approval of the court upon submission by the liquidator. In the event
2092 that the property of the insurer does not contain sufficient cash or
2093 liquid assets to defray the costs incurred, the commissioner may
2094 advance the costs so incurred out of any appropriation for the
2095 maintenance of the Insurance Department. Any amounts so advanced
2096 for expenses of administration shall be repaid to the commissioner for
2097 the use of the Insurance Department out of the first available moneys
2098 of the insurer; (5) to hold hearings, to subpoena witnesses, to compel
2099 their attendance, to administer oaths, to examine any person under
2100 oath and to compel any person to subscribe to **[**his**]** such person's
2101 testimony after it has been correctly reduced to writing, and in
2102 connection therewith to require the production of any books, papers,
2103 records or other documents which **[**he**]** the liquidator deems relevant
2104 to the inquiry; (6) to collect all debts and moneys due and claims
2105 belonging to the insurer, wherever located, and for this purpose (A) to
2106 institute timely action in other jurisdictions in order to forestall
2107 garnishment and attachment proceedings against such debts; (B) to do
2108 such other acts as are necessary or expedient to collect, conserve or
2109 protect its assets or property, including the power to sell, compound,
2110 compromise or assign debts for purposes of collection upon such terms
2111 and conditions as **[**he**]** the liquidator deems best; and (C) to pursue any
2112 creditor's remedies available to enforce the creditor's claims; (7) to
2113 conduct public and private sales of the property of the insurer; (8) to
2114 use assets of the estate of an insurer under a liquidation order to
2115 transfer policy obligations to a solvent assuming insurer, if the transfer
2116 can be arranged without prejudice to applicable priorities under
2117 section 38a-944; (9) to acquire, hypothecate, encumber, lease, improve,
2118 sell, transfer, abandon or otherwise dispose of or deal with, any
2119 property of the insurer at its market value or upon such terms and
2120 conditions as are fair and reasonable. The liquidator shall also have
2121 power to execute, acknowledge and deliver any and all deeds,

2122 assignments, releases and other instruments necessary or proper to
2123 effectuate any sale of property or other transaction in connection with
2124 the liquidation; (10) to borrow money on the security of the assets in
2125 the insurer's estate or without security and to execute and deliver all
2126 documents necessary to that transaction for the purpose of facilitating
2127 the liquidation. Any such funds borrowed may be repaid as an
2128 administrative expense and have priority over any other claims in class
2129 1 under the priority of distributions; (11) to enter into such contracts as
2130 are necessary to carry out the order to liquidate and to affirm or
2131 disavow any contracts to which the insurer is a party; (12) to continue
2132 to prosecute and to institute in the name of the insurer or in the
2133 liquidator's own name any and all suits and other legal proceedings, in
2134 this state or elsewhere, and to abandon the prosecution of claims **[**he**]**
2135 the liquidator deems unprofitable to pursue further. If the insurer is
2136 dissolved pursuant to section 38a-922, the liquidator shall have the
2137 power to apply to any court in this state or elsewhere for leave to
2138 substitute the liquidator for the insurer as plaintiff; (13) to prosecute
2139 any action which may exist on behalf of the creditors, members,
2140 policyholders or shareholders of the insurer against any officer of the
2141 insurer or any other person; (14) to remove any or all records and
2142 property of the insurer to the offices of the commissioner or to such
2143 other place as may be convenient for the purposes of efficient and
2144 orderly execution of the liquidation. Guaranty associations shall have
2145 such reasonable access to the records of the insurer as is necessary for
2146 them to carry out their statutory obligations; (15) to deposit in one or
2147 more banks in this state such sums as are required for meeting current
2148 administration expenses and dividend distributions; (16) to invest all
2149 sums not currently needed, unless the court orders otherwise; (17) to
2150 file any necessary documents for record in the office of any recorder of
2151 deeds or record office in this state or elsewhere where property of the
2152 insurer is located; (18) to assert all defenses available to the insurer as
2153 against third persons, including statutes of limitation, statutes of
2154 frauds and the defense of usury. A waiver of any defense by the
2155 insurer after a petition in liquidation has been filed shall not bind the
2156 liquidator. Whenever a guaranty association or foreign guaranty

2157 association has an obligation to defend any suit, the liquidator shall
2158 give precedence to such obligation and may defend only in the absence
2159 of a defense by such guaranty associations; (19) to exercise and enforce
2160 all the rights, remedies **[**,**]** and powers of any creditor, shareholder,
2161 policyholder **[**,**]** or member, including any power to avoid any transfer
2162 or lien that may be given by the general law and that is not included
2163 **[**with**]** under sections 38a-928 to 38a-930, inclusive; (20) to intervene in
2164 any proceeding wherever instituted that might lead to the
2165 appointment of a receiver or trustee and to act as the receiver or trustee
2166 whenever the appointment is offered; (21) to enter into agreements
2167 with any receiver or commissioner of any other state relating to the
2168 rehabilitation, liquidation, conservation or dissolution of an insurer
2169 doing business in both states; (22) to exercise all powers conferred
2170 upon receivers by the laws of this state not inconsistent with the
2171 provisions of sections 38a-903 to 38a-961, inclusive; (23) to appoint,
2172 with the approval of the court, an advisory committee of
2173 policyholders, claimants or other creditors including guaranty
2174 associations should such a committee be deemed necessary. The
2175 committee shall serve at the pleasure of the commissioner and the
2176 decision to appoint an advisory committee shall be at the sole
2177 discretion of the commissioner. The committee shall serve without
2178 compensation and without reimbursement for expenses. No other
2179 committee shall be appointed by the commissioner or the court in
2180 liquidation proceedings conducted under sections 38a-903 to 38a-961,
2181 inclusive; and (24) to audit the books and records of all agents of the
2182 insurer insofar as those records relate to the business activities of the
2183 insurer.

2184 Sec. 47. Section 38a-962h of the general statutes is repealed and the
2185 following is substituted in lieu thereof (*Effective from passage*):

2186 Notwithstanding any other provision of law, **[**to the contrary,**]** the
2187 commissioner may meet with a supervisor appointed under sections
2188 38a-129, 38a-140 and 38a-962 to 38a-962j, inclusive, and with the
2189 attorney or other representative of the supervisor, without the
2190 presence of any other person, at the time of any proceeding or during

2191 the pendency of any proceeding held under authority of said sections
2192 to carry out the commissioner's duties under said sections or for the
2193 supervisor to carry out his duties under said sections.

2194 Sec. 48. Section 14-64 of the general statutes is repealed and the
2195 following is substituted in lieu thereof (*Effective from passage*):

2196 The commissioner may suspend or revoke the license or licenses of
2197 any licensee or impose a civil penalty of not more than one thousand
2198 dollars for each violation on any licensee or both, when, after notice
2199 and hearing, the commissioner finds that the licensee (1) has violated
2200 any provision of any statute or regulation of any state or any federal
2201 statute or regulation pertaining to its business as a licensee or has
2202 failed to comply with the terms of a final decision and order of any
2203 state department or federal agency concerning any such provision; or
2204 (2) has failed to maintain such records of transactions concerning the
2205 purchase, sale or repair of motor vehicles or major component parts, as
2206 required by such regulations as shall be adopted by the commissioner,
2207 for a period of two years after such purchase, sale or repairs, provided
2208 the records shall include the vehicle identification number and the
2209 name and address of the person from whom each vehicle or part was
2210 purchased and to whom each vehicle or part was sold, if a sale
2211 occurred; or (3) has failed to allow inspection of such records by the
2212 commissioner or the commissioner's representative during normal
2213 business hours, provided written notice stating the purpose of the
2214 inspection is furnished to the licensee, or has failed to allow inspection
2215 of such records by any representative of the Division of State Police
2216 within the Department of Public Safety or any organized local police
2217 department, which inspection may include examination of the
2218 premises to determine the accuracy of such records; or (4) has made a
2219 false statement as to the condition, prior ownership or prior use of any
2220 motor vehicle sold, exchanged, transferred, offered for sale or repaired
2221 if the licensee knew or should have known that such statement was
2222 false; or (5) is not qualified to conduct the licensed business, applying
2223 the standards of section 14-51 and the applicable regulations; or (6) has
2224 violated any provision of sections 42-221 to 42-226, inclusive; or (7) has

2225 failed to fully execute or provide the buyer with (A) an order as
2226 described in section 14-62, (B) the properly assigned certificate of title,
2227 or (C) a temporary transfer or new issue of registration; or (8) has
2228 failed to deliver a motor vehicle free and clear of all liens, unless
2229 written notification is given to the buyer stating such motor vehicle
2230 shall be purchased subject to a lien; or (9) has violated any provision of
2231 sections 14-65f to 14-65j, inclusive, and section 14-65*l*; or (10) has used
2232 registration number plates issued by the commissioner, in violation of
2233 the provisions and standards set forth in sections 14-59 and 14-60 and
2234 the applicable regulations; or (11) has failed to secure or to account for
2235 or surrender to the commissioner on demand official registration
2236 plates or any other official materials in its custody. In addition to, or in
2237 lieu of, the imposition of any other penalties authorized by this section,
2238 the commissioner may order any such licensee to make restitution to
2239 any aggrieved customer.

2240 Sec. 49. Subsection (a) of section 14-65g of the general statutes is
2241 repealed and the following is substituted in lieu thereof (*Effective from*
2242 *passage*):

2243 (a) A customer may waive his right to the estimate of the costs of
2244 parts and labor required by section 14-65f, only in writing in
2245 accordance with this section. Such a waiver shall include an
2246 authorization to perform reasonable and necessary repairs to remedy
2247 the problems complained of, at a cost not to exceed a fixed dollar
2248 amount. The waiver shall be signed by the customer and the customer
2249 shall be given a fully completed copy of the waiver at the time it is
2250 signed. No repair shop shall use waivers to evade its duties under
2251 sections 14-65e to 14-65j, inclusive, and section 14-65*l*.

2252 Sec. 50. Section 14-65k of the general statutes is repealed and the
2253 following is substituted in lieu thereof (*Effective from passage*):

2254 (a) The Commissioner of Motor Vehicles may conduct
2255 investigations and hold hearings on any matter under the provisions of
2256 sections 14-51 to 14-65j, inclusive, and section 14-65*l*. The

2257 commissioner may issue subpoenas, administer oaths, compel
2258 testimony and order the production of books, records and documents.
2259 If any person refuses to appear, to testify or to produce any book,
2260 record, paper or document when so ordered, upon application of the
2261 commissioner, a judge of the Superior Court may make such order as
2262 may be appropriate to aid in the enforcement of this section.

2263 (b) The Attorney General, at the request of the commissioner, is
2264 authorized to apply in the name of the state of Connecticut to the
2265 Superior Court for an order temporarily or permanently restraining
2266 and enjoining any person from violating any provision of sections 14-
2267 51 to 14-65j, inclusive, and section 14-65*l*.

2268 Sec. 51. Section 20-327b of the 2010 supplement to the general
2269 statutes is repealed and the following is substituted in lieu thereof
2270 (*Effective from passage*):

2271 (a) Except as otherwise provided in this section, each person who
2272 offers residential property in the state for sale, exchange or for lease
2273 with option to buy, shall provide a written residential condition report
2274 to the prospective purchaser at any time prior to the prospective
2275 purchaser's execution of any binder, contract to purchase, option **[,]** or
2276 lease containing a purchase option. A photocopy, duplicate original,
2277 facsimile transmission **[,]** or other exact reproduction or duplicate of
2278 the written residential condition report containing the prospective
2279 purchaser's written receipt shall be attached to any written offer,
2280 binder or contract to purchase. A photocopy, duplicate original,
2281 facsimile transmission or other exact reproduction or duplicate of the
2282 written residential condition report containing the signatures of both
2283 seller and purchaser **[,]** shall be attached to any agreement to purchase
2284 the property.

2285 (b) The following shall be exempt from the provisions of this
2286 section: (1) Any transfer from one or more co-owners solely to one or
2287 more of the co-owners; (2) transfers made to the spouse, mother,
2288 father, brother, sister, child, grandparent or grandchild of the

2289 transferor where no consideration is paid; (3) transfers pursuant to an
2290 order of the court; (4) transfers of newly-constructed residential real
2291 property for which an implied warranty is provided under chapter
2292 827; (5) transfers made by executors, administrators, trustees or
2293 conservators; (6) transfers by the federal government, any political
2294 subdivision thereof or any corporation, institution or quasi-
2295 governmental agency chartered by the federal government; (7)
2296 transfers by deed in lieu of foreclosure; (8) transfers by the state of
2297 Connecticut or any political subdivision thereof; (9) transfers of
2298 property which was the subject of a contract or option entered into
2299 prior to January 1, 1996; and (10) any transfer of property acquired by
2300 a judgment of strict foreclosure or by foreclosure by sale or by a deed
2301 in lieu of foreclosure.

2302 (c) The provisions of this section shall apply only to transfers by
2303 sale, exchange or lease with option to buy, of residential real property
2304 consisting of not less than one nor more than four dwelling units
2305 which shall include cooperatives and condominiums, and shall apply
2306 to all transfers, with or without the assistance of a licensed real estate
2307 broker or salesperson, as defined in section 20-311.

2308 (d) (1) Not later than April 1, 2010, the Commissioner of Consumer
2309 Protection **[,]** shall, by regulations adopted in accordance with the
2310 provisions of chapter 54, prescribe the form of the written residential
2311 disclosure report required by this section and sections 20-327c to 20-
2312 327e, inclusive. The regulations shall provide that the form include
2313 information concerning:

2314 (A) Municipal assessments, including, but not limited to, sewer or
2315 water charges applicable to the property. Such information shall
2316 include: (i) Whether such assessment is in effect and the amount of the
2317 assessment; (ii) whether there is an assessment on the property that
2318 has not been paid, and if so, the amount of the unpaid assessment; and
2319 (iii) to the extent of the seller's knowledge, whether there is reason to
2320 believe that the municipality may impose an assessment in the future;

2321 (B) Leased items on the premises, including, but not limited to,
2322 propane fuel tanks, water heaters, major appliances and alarm
2323 systems; and

2324 (C) (i) Whether the real property is located in a municipally
2325 designated village district or municipally designated historic district or
2326 has been designated on the National Register of Historic Places, and
2327 (ii) a statement that information concerning village districts and
2328 historic districts may be obtained from the municipality's village or
2329 historic district commission, if applicable.

2330 (2) Such form of the written residential disclosure report shall
2331 contain the following:

2332 (A) A certification by the seller in the following form:

2333 "To the extent of the seller's knowledge as a property owner, the
2334 seller acknowledges that the information contained above is true and
2335 accurate for those areas of the property listed. In the event a real estate
2336 broker or salesperson is utilized, the seller authorizes the brokers or
2337 salespersons to provide the above information to prospective buyers,
2338 selling agents or buyers' agents.

T1 .... (Date) .... (Seller)
T2 .... (Date) .... (Seller)"

2339 (B) A certification by the buyer in the following form:

2340 "The buyer is urged to carefully inspect the property and, if desired,
2341 to have the property inspected by an expert. The buyer understands
2342 that there are areas of the property for which the seller has no
2343 knowledge and that this disclosure statement does not encompass
2344 those areas. The buyer also acknowledges that the buyer has read and
2345 received a signed copy of this statement from the seller or seller's
2346 agent.

T3 .... (Date) .... (Seller)
T4 .... (Date) .... (Seller)"

2347 (C) A statement concerning the responsibility of real estate brokers
2348 in the following form:

2349 "This report in no way relieves a real estate broker of the broker's
2350 obligation under the provisions of section 20-328-5a of the Regulations
2351 of Connecticut State Agencies to disclose any material facts. Failure to
2352 do so could result in punitive action taken against the broker, such as
2353 fines, suspension or revocation of license."

2354 (D) A statement that any representations made by the seller on the
2355 written residential disclosure report shall not constitute a warranty to
2356 the buyer.

2357 (E) A statement that the written residential disclosure report is not a
2358 substitute for inspections, tests and other methods of determining the
2359 physical condition of property.

2360 (F) Information concerning environmental matters such as lead,
2361 radon, subsurface sewage disposal, flood hazards and, if the residence
2362 is or will be served by well water, as defined in section 21a-150, the
2363 results of any water test performed for volatile organic compounds
2364 and such other topics as the Commissioner of Consumer Protection
2365 may determine would be of interest to a buyer.

2366 (G) A statement that information concerning the residence address
2367 of a person convicted of a crime may be available from law
2368 enforcement agencies or the Department of Public Safety and that the
2369 Department of Public Safety maintains a site on the Internet listing
2370 information about the residence address of persons required to register
2371 under section 54-251, 54-252, 54-253 or 54-254, who have so registered.

2372 (e) On or after January 1, 1996, the Commissioner of Consumer
2373 Protection shall make available the residential disclosure report
2374 prescribed in accordance with the provisions of this section and

2375 sections 20-327c to 20-327e, inclusive, to the Division of Real Estate, all
2376 municipal town clerks, the Connecticut Association of Realtors, Inc.,
2377 and any other person or institution that the commissioner believes
2378 would aid in the dissemination and distribution of such form. The
2379 commissioner shall also cause information concerning such form and
2380 the completion of such form to be disseminated in a manner best
2381 calculated, in the commissioner's judgment, to reach members of the
2382 public, attorneys and real estate licensees.

2383 Sec. 52. Section 29-152n of the general statutes is repealed and the
2384 following is substituted in lieu thereof (*Effective from passage*):

2385 Any person who violates any provision of sections 29-152e to
2386 29-152m, inclusive, **[**and 38a-660a**]** shall be guilty of a class D felony.

2387 Sec. 53. Subsection (f) of section 42-103jj of the 2010 supplement to
2388 the general statutes is repealed and the following is substituted in lieu
2389 thereof (*Effective from passage*):

2390 (f) In lieu of physically providing the items listed in subsection (e) of
2391 this section, a developer filing an abbreviated application may provide
2392 a statement or statements certifying that any or all of the items
2393 required by subsection (e) of this section are available to be viewed
2394 electronically, at no cost to the department, through an electronic
2395 registry, web site or other electronic means approved by the
2396 commissioner. The method for accessing **[**said**]** <u>such</u> items shall be
2397 clearly disclosed in each such certification.

2398 Sec. 54. Subsection (a) of section 42-103kk of the 2010 supplement to
2399 the general statutes is repealed and the following is substituted in lieu
2400 thereof (*Effective from passage*):

2401 (a) The commissioner may adopt regulations, in accordance with
2402 chapter 54, and prescribe and publish forms necessary to carry out the
2403 provisions of sections 42-103cc to 42-103ddd, inclusive. **[**The**]** <u>If, after</u>
2404 <u>notice and hearing, the commissioner determines that a developer or</u>
2405 <u>person subject to sections 42-103cc to 42-103ddd, inclusive, has</u>

2406 materially violated any provision of sections 42-103cc to 42-103ddd,
2407 inclusive, or chapter 735a, the commissioner may (1) suspend or
2408 revoke the registration of, place on probation [,] or reprimand any
2409 person subject to sections 42-103cc to 42-103ddd, inclusive, (2) impose
2410 a civil penalty of not more than five thousand dollars for each violation
2411 of sections 42-103cc to 42-103ddd, inclusive, or (3) take any other
2412 disciplinary action authorized by sections 42-103cc to 42-103ddd,
2413 inclusive. [, if, after notice and hearing, the commissioner determines
2414 that a developer or person subject to sections 42-103cc to 42-103ddd,
2415 inclusive, has materially violated any provision of sections 42-103cc to
2416 42-103ddd, inclusive, or chapter 735a.] Nothing in sections 42-103cc to
2417 42-103ddd, inclusive, shall be construed to limit or deny any rights or
2418 remedies provided by law.

2419 Sec. 55. Subdivision (16) of subsection (b) of section 42-103mm of the
2420 2010 supplement to the general statutes is repealed and the following
2421 is substituted in lieu thereof (*Effective from passage*):

2422 (16) A description of any bankruptcy of the developer that is
2423 pending or that has occurred within the past five years, pending civil
2424 or criminal suit, adjudication or disciplinary actions material to the
2425 time share plan of which the developer has knowledge;

2426 Sec. 56. Subdivision (25) of subsection (d) of section 42-103mm of
2427 the 2010 supplement to the general statutes is repealed and the
2428 following is substituted in lieu thereof (*Effective from passage*):

2429 (25) A description of the cancellation provisions and the waiver
2430 prohibition set forth in subsections (a) to (c), inclusive, of section 42-
2431 103pp;

2432 Sec. 57. Subdivision (1) of subsection (c) of section 42-103uu of the
2433 2010 supplement to the general statutes is repealed and the following
2434 is substituted in lieu thereof (*Effective from passage*):

2435 (1) An institutional lender to a developer, for [so] as long as such
2436 lender holds a mortgage encumbering any interest in or lien against a

2437 portion of the time share property; or

2438 Sec. 58. Section 42-500 of the 2010 supplement to the general statutes
2439 is repealed and the following is substituted in lieu thereof (*Effective*
2440 *from passage, and applicable to commercial leases entered, renewed, modified*
2441 *or extended on or after the effective date of this section*):

2442 (a) If any insurance is required to be obtained for a lease pursuant to
2443 subsection (e) of section 42a-2A-305, any such agreement as set forth in
2444 said subsection shall disclose in a conspicuous manner: (1) Whether
2445 the insurance is included in the lease for no additional charge; (2) if the
2446 insurance is not included in the lease or if there is an additional charge
2447 for obtaining insurance through the lessor, that the lessee may
2448 purchase the required insurance from an insurer of the lessee's choice,
2449 subject to the lessor's right to reject that insurer for reasonable cause;
2450 and (3) that the insurance policies offered by the lessor may duplicate
2451 coverage already provided by a lessee's personal insurance policies.

2452 (b) If insurance on the leased goods is neither required nor provided
2453 in such lease or by agreement, the lease **[**must**]** shall contain or be
2454 accompanied by a conspicuous statement in a record substantially as
2455 follows: "No insurance coverage for the leased goods, or loss of the
2456 leased goods, is provided under this lease.".

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	38a-9(b)(2)
Sec. 2	*from passage*	38a-25(a)(15)
Sec. 3	*from passage*	38a-55(b)(3)
Sec. 4	*from passage*	38a-60(c)
Sec. 5	*from passage*	38a-91ff(d)
Sec. 6	*from passage*	38a-91k
Sec. 7	*from passage*	38a-102(d)
Sec. 8	*from passage*	38a-307a
Sec. 9	*from passage*	38a-336(a)(2)
Sec. 10	*from passage*	38a-352
Sec. 11	*from passage*	38a-433(a)

Sec. 12	*from passage*	38a-439(e)
Sec. 13	*from passage*	38a-465a
Sec. 14	*from passage*	38a-465c(a)
Sec. 15	*from passage*	38a-465g
Sec. 16	*from passage*	38a-478c(a)(1)
Sec. 17	*from passage*	38a-479rr(b)
Sec. 18	*from passage*	38a-481(b)
Sec. 19	*from passage*	38a-483(b)(6)
Sec. 20	*January 1, 2011*	38a-491a
Sec. 21	*January 1, 2011*	38a-492j
Sec. 22	*from passage*	38a-495a(f)
Sec. 23	*January 1, 2011*	38a-500(a)
Sec. 24	*January 1, 2011*	38a-504
Sec. 25	*from passage*	38a-511(c)
Sec. 26	*from passage*	38a-513e
Sec. 27	*January 1, 2011*	38a-517a(a)
Sec. 28	*January 1, 2011*	38a-518j
Sec. 29	*January 1, 2011*	38a-527(a)
Sec. 30	*from passage*	38a-538
Sec. 31	*January 1, 2011*	38a-542
Sec. 32	*January 1, 2011*	38a-546(a)
Sec. 33	*from passage*	38a-556
Sec. 34	*from passage*	38a-564(3) and (4)
Sec. 35	*from passage*	38a-569
Sec. 36	*from passage*	38a-760a(7)
Sec. 37	*from passage*	38a-790(d)(2)
Sec. 38	*from passage*	38a-839
Sec. 39	*from passage*	38a-840
Sec. 40	*from passage*	38a-841
Sec. 41	*from passage*	38a-842
Sec. 42	*from passage*	38a-843
Sec. 43	*from passage*	38a-844
Sec. 44	*from passage*	38a-845
Sec. 45	*from passage*	38a-916(a)
Sec. 46	*from passage*	38a-923(a)
Sec. 47	*from passage*	38a-962h
Sec. 48	*from passage*	14-64
Sec. 49	*from passage*	14-65g(a)
Sec. 50	*from passage*	14-65k
Sec. 51	*from passage*	20-327b

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

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.

House "A" eliminates a section of the underlying bill that makes technical changes to an existing statute, does not result in a fiscal impact.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation. 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 (as amended by House "A")*

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.

*House Amendment "A" deletes technical 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 as amended by PA 09-237)

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 § 14-65*l*).

The law prohibits a motor vehicle repair shop from repairing a vehicle 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 § 14-65f). 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 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)

Transportation Committee

Joint Favorable
Yea 26 Nay 0 (03/29/2010)

Judiciary Committee

Joint Favorable
Yea 40 Nay 0 (04/07/2010)