



# Senate

General Assembly

**File No. 288**

February Session, 2010

Substitute Senate Bill No. 93

*Senate, April 6, 2010*

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

## ***AN ACT CONCERNING REVISIONS TO THE INSURANCE STATUTES.***

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

1 Section 1. Subsection (d) of section 38a-8 of the general statutes is  
2 repealed and the following is substituted in lieu thereof (*Effective*  
3 *October 1, 2010*):

4 (d) The commissioner shall develop a program of periodic review to  
5 ensure compliance by the Insurance Department with the minimum  
6 standards established by the National Association of Insurance  
7 Commissioners for effective financial surveillance and regulation of  
8 insurance companies operating in this state. The commissioner shall  
9 adopt regulations, in accordance with the provisions of chapter 54,  
10 pertaining to the financial surveillance and solvency regulation of  
11 insurance companies and health care centers as are reasonable and  
12 necessary to obtain or maintain the accreditation of the Insurance  
13 Department by the National Association of Insurance Commissioners.  
14 The commissioner shall maintain, as confidential, any confidential  
15 documents or information received from the National Association of

16 Insurance Commissioners, or the International Association of  
17 Insurance Supervisors, or any documents or information received from  
18 state or federal insurance, banking or securities regulators or similar  
19 regulators in a foreign country which are confidential in such  
20 jurisdictions. The commissioner may share any information, including  
21 confidential information, with the National Association of Insurance  
22 Commissioners, the International Association of Insurance  
23 Supervisors, or state or federal insurance, banking or securities  
24 regulators or similar regulators in a foreign country so long as the  
25 commissioner determines that such entities agree to maintain the same  
26 level of confidentiality in their jurisdiction as is available in this state.  
27 The commissioner may engage the services of [, at the expense of a  
28 domestic, alien or foreign insurer,] attorneys, actuaries, accountants  
29 and other experts not otherwise part of the commissioner's staff as may  
30 be necessary, at the expense of a domestic, alien or foreign insurer or  
31 other entity requiring licensure or registration under this title, to assist  
32 the commissioner in the financial analysis of the insurer or other entity,  
33 the review of the insurer's or other entity's license or registration  
34 applications, and the review of transactions within a holding company  
35 system involving an insurer domiciled in this state. No duties of a  
36 person employed by the Insurance Department on November 1, 2002,  
37 shall be performed by such attorney, actuary, accountant or expert.

38 Sec. 2. Section 38a-9 of the 2010 supplement to the general statutes is  
39 repealed and the following is substituted in lieu thereof (*Effective from*  
40 *passage*):

41 (a) Notwithstanding the provisions of section 4-8, there shall be a  
42 [Division of Consumer Affairs] division within the Insurance  
43 Department [, which division] that shall act on the Insurance  
44 Commissioner's behalf and at [his] said commissioner's direction in  
45 order to carry out his responsibilities under this title with respect to  
46 [such] consumer and market conduct matters. The division shall  
47 receive and review complaints from residents of this state concerning  
48 their insurance problems, including claims disputes, and serve as a  
49 mediator in such disputes in order to assist the commissioner in

50 determining whether statutory requirements and contractual  
51 obligations within the commissioner's jurisdiction have been fulfilled.  
52 There shall be a director of said division, who shall be provided with  
53 sufficient staff. The division shall serve to coordinate all appropriate  
54 facilities in the department in addressing such complaints, and  
55 conduct any outreach programs deemed necessary to properly inform  
56 and educate the public on insurance matters. The director shall submit  
57 quarterly reports to the commissioner, which shall state the number of  
58 complaints received by the division in such calendar quarter, the  
59 Connecticut premium volume of the appropriate line of each insurance  
60 company against which a complaint has been filed, the types of  
61 complaints received, and the number of such complaints which have  
62 been resolved. Such reports shall be published every six months and  
63 copies shall be made available to any interested resident of this state  
64 upon request. The commissioner shall report, in accordance with  
65 section 11-4a, to the joint standing committee of the General Assembly  
66 having cognizance of matters relating to insurance on or before  
67 January fifteenth, annually, concerning the findings of such reports  
68 and suggestions for legislative initiatives to address recurring  
69 problems.

70 (b) (1) The [Division of Consumer Affairs] division set forth in  
71 subsection (a) of this section shall provide an independent arbitration  
72 procedure for the settlement of disputes between claimants and  
73 insurance companies concerning automobile physical damage and  
74 automobile property damage liability claims in which liability and  
75 coverage are not in dispute. Such procedure shall apply only to  
76 disputes involving private passenger motor vehicles as defined in  
77 subsection (e) of section 38a-363. Any company licensed to write  
78 private passenger automobile insurance, including collision,  
79 comprehensive and theft, in this state shall participate in the  
80 arbitration procedure. The commissioner shall appoint an  
81 administrator for such procedure. Only those disputes in which  
82 attempts at mediation by [the Division of Consumer Affairs] said  
83 division have failed shall be accepted as arbitrable. The referral of the  
84 complaint to arbitration shall be made by the Insurance Department

85 examiner who investigated the complaint. [Each party to] The claimant  
86 and the insurance company involved in the dispute shall pay a filing  
87 fee of [twenty] fifty dollars and one hundred dollars, respectively. The  
88 insurance company shall pay the consumer the undisputed amount of  
89 the claim upon written notification from the department that the  
90 complaint has been referred to arbitration. Such payment shall not  
91 affect any right of the consumer to pursue the disputed amount of the  
92 claim.

93 (2) The commissioner shall prepare a list of at least ten persons, who  
94 have not been employed by the department or an insurance company  
95 during the preceding twelve months, to serve as arbitrators in the  
96 settlement of such disputes. The arbitrators shall be members of any  
97 dispute resolution organization approved by the commissioner. One  
98 arbitrator shall be appointed to hear and decide each complaint.  
99 Appointment shall be based solely on the order of the list. If an  
100 arbitrator is unable to serve on a given day, or if either party objects to  
101 the arbitrator, then the next arbitrator on the list will be selected. The  
102 department shall schedule arbitration hearings as often, and in such  
103 locations, as it deems necessary. Parties to the dispute shall be  
104 provided written notice of the hearing, at least ten days prior to the  
105 hearing date. The commissioner may issue subpoenas on behalf of the  
106 arbitrator to compel the attendance of witnesses and the production of  
107 documents, papers and records relevant to the dispute. Decisions shall  
108 be made on the basis of the evidence presented at the arbitration  
109 hearing. Where the arbitrator believes that technical expertise is  
110 necessary to decide a case, he may consult with an independent expert  
111 recommended by the commissioner. The arbitrator and any  
112 independent technical expert shall be paid by the department on a per  
113 dispute basis as established by the commissioner. The arbitrator, as  
114 expeditiously as possible, but not later than fifteen days after the  
115 arbitration hearing, shall render a written decision based on the  
116 information gathered and disclose the findings and the reasons to the  
117 parties involved. The arbitrator shall award filing fees to the prevailing  
118 party. If the decision favors the consumer the decision shall provide  
119 specific and appropriate remedies including interest at the rate of ten

120 per cent on the arbitration award concerning the disputed amount of  
121 the claim, retroactive to the date of payment for the undisputed  
122 amount of the claim. The decision may include costs for loss of use and  
123 storage of the motor vehicle and shall specify a date for performance  
124 and completion of all awarded remedies. Notwithstanding any  
125 provision of the general statutes or any regulation to the contrary, the  
126 Insurance Department shall not amend, reverse, rescind, or revoke any  
127 decision or action of any arbitrator. The department shall contact the  
128 consumer within ten working days after the date for performance, to  
129 determine whether performance has occurred. Either party may make  
130 application to the superior court for the judicial district in which one of  
131 the parties resides or, when the court is not in session, any judge  
132 thereof for an order confirming, vacating, modifying or correcting any  
133 award, in accordance with the provisions of sections 52-417, 52-418, 52-  
134 419 and 52-420. If it is determined by the court that either party's  
135 position after review has been improved by at least ten per cent over  
136 that party's position after arbitration, the court, in its discretion, may  
137 grant to that party its costs and reasonable attorney's fees. No  
138 evidence, testimony, findings, or decision from the department  
139 arbitration procedure shall be admissible in any civil proceeding,  
140 except judicial review of the arbitrator's decision as contemplated by  
141 this subsection.

142 (3) The department shall maintain records of each dispute,  
143 including names of parties to the arbitration, the decision of the  
144 arbitrator, compliance, the appeal, if any, and the decision of the court.  
145 The department shall annually compile such statistics and send a copy  
146 to the committee of the General Assembly having cognizance of  
147 matters relating to insurance. The report shall be considered a public  
148 document.

149 (c) Notwithstanding the provisions of section 4-8, there shall be [a  
150 Division of Rate Review] divisions within the Insurance Department [,  
151 which division] that shall act on the commissioner's behalf and at the  
152 commissioner's direction in order to carry out the commissioner's  
153 responsibilities under this title with respect to [such matters] rate

154 review. Subject to the provisions of sections 38a-663 to 38a-696,  
155 inclusive, the [division] divisions shall assist the commissioner in  
156 reviewing rates and supplementary rate information filed with the  
157 department for compliance with statutory requirements and  
158 standards. The [division's staff] divisions' staffs shall include rating  
159 examiners with sufficient actuarial expertise. Upon the request of the  
160 commissioner, the [division] divisions shall review rates and  
161 supplementary rate information, and any suspected violation of the  
162 statutory requirements and standards of sections 38a-663 to 38a-696,  
163 inclusive, found pursuant to such review shall be referred to the  
164 commissioner for appropriate action. The [division] divisions may  
165 assist the commissioner in formalizing the commissioner's findings  
166 regarding such actions. The commissioner shall report, in accordance  
167 with section 11-4a, to the joint standing committee of the General  
168 Assembly having cognizance of matters relating to insurance on or  
169 before January fifteenth annually, concerning (1) the number and type  
170 of reviews conducted by the property and casualty division in the  
171 prior calendar year, and (2) the percentage of increase or decrease in  
172 rates reviewed by the property and casualty division during the  
173 preceding calendar year, by line and subline of insurance.

174 (d) The directors and staff of [both the Division of Consumer Affairs  
175 and the Division of Rate Review] the divisions set forth in subsections  
176 (a) and (c) of this section shall be appointed by the commissioner  
177 under the provisions of chapter 67.

178 Sec. 3. Subsection (a) of section 38a-11 of the 2010 supplement to the  
179 general statutes is repealed and the following is substituted in lieu  
180 thereof (*Effective October 1, 2010*):

181 (a) The commissioner shall demand and receive the following fees:  
182 (1) For the annual fee for each license issued to a domestic insurance  
183 company, two hundred dollars; (2) for receiving and filing annual  
184 reports of domestic insurance companies, fifty dollars; (3) for filing all  
185 documents prerequisite to the issuance of a license to an insurance  
186 company, two hundred twenty dollars, except that the fee for such

187 filings by any health care center, as defined in section 38a-175, shall be  
188 one thousand three hundred fifty dollars; (4) for filing any additional  
189 paper required by law, thirty dollars; (5) for each certificate of  
190 valuation, organization, reciprocity or compliance, forty dollars; (6) for  
191 each certified copy of a license to a company, forty dollars; (7) for each  
192 certified copy of a report or certificate of condition of a company to be  
193 filed in any other state, forty dollars; (8) for amending a certificate of  
194 authority, two hundred dollars; (9) for each license issued to a rating  
195 organization, two hundred dollars. In addition, insurance companies  
196 shall pay any fees imposed under section 12-211; (10) a filing fee of  
197 fifty dollars for each initial application for a license made pursuant to  
198 section 38a-769; (11) with respect to insurance agents' appointments:  
199 (A) A filing fee of fifty dollars for each request for any agent  
200 appointment, except that no filing fee shall be payable for a request for  
201 agent appointment by an insurance company domiciled in a state or  
202 foreign country which does not require any filing fee for a request for  
203 agent appointment for a Connecticut insurance company; (B) a fee of  
204 one hundred dollars for each appointment issued to an agent of a  
205 domestic insurance company or for each appointment continued; and  
206 (C) a fee of eighty dollars for each appointment issued to an agent of  
207 any other insurance company or for each appointment continued,  
208 except that (i) no fee shall be payable for an appointment issued to an  
209 agent of an insurance company domiciled in a state or foreign country  
210 which does not require any fee for an appointment issued to an agent  
211 of a Connecticut insurance company, and (ii) the fee shall be twenty  
212 dollars for each appointment issued or continued to an agent of an  
213 insurance company domiciled in a state or foreign country with a  
214 premium tax rate below Connecticut's premium tax rate; (12) with  
215 respect to insurance producers: (A) An examination fee of fifteen  
216 dollars for each examination taken, except when a testing service is  
217 used, the testing service shall pay a fee of fifteen dollars to the  
218 commissioner for each examination taken by an applicant; (B) a fee of  
219 eighty dollars for each license issued; (C) a fee of eighty dollars per  
220 year, or any portion thereof, for each license renewed; and (D) a fee of  
221 eighty dollars for any license renewed under the transitional process

222 established in section 38a-784; (13) with respect to public adjusters: (A)  
223 An examination fee of fifteen dollars for each examination taken,  
224 except when a testing service is used, the testing service shall pay a fee  
225 of fifteen dollars to the commissioner for each examination taken by an  
226 applicant; and (B) a fee of two hundred fifty dollars for each license  
227 issued or renewed; (14) with respect to casualty adjusters: (A) An  
228 examination fee of twenty dollars for each examination taken, except  
229 when a testing service is used, the testing service shall pay a fee of  
230 twenty dollars to the commissioner for each examination taken by an  
231 applicant; (B) a fee of eighty dollars for each license issued or renewed;  
232 and (C) the expense of any examination administered outside the state  
233 shall be the responsibility of the entity making the request and such  
234 entity shall pay to the commissioner two hundred dollars for such  
235 examination and the actual traveling expenses of the examination  
236 administrator to administer such examination; (15) with respect to  
237 motor vehicle physical damage appraisers: (A) An examination fee of  
238 eighty dollars for each examination taken, except when a testing  
239 service is used, the testing service shall pay a fee of eighty dollars to  
240 the commissioner for each examination taken by an applicant; (B) a fee  
241 of eighty dollars for each license issued or renewed; and (C) the  
242 expense of any examination administered outside the state shall be the  
243 responsibility of the entity making the request and such entity shall  
244 pay to the commissioner two hundred dollars for such examination  
245 and the actual traveling expenses of the examination administrator to  
246 administer such examination; (16) with respect to certified insurance  
247 consultants: (A) An examination fee of twenty-six dollars for each  
248 examination taken, except when a testing service is used, the testing  
249 service shall pay a fee of twenty-six dollars to the commissioner for  
250 each examination taken by an applicant; (B) a fee of two hundred fifty  
251 dollars for each license issued; and (C) a fee of two hundred fifty  
252 dollars for each license renewed; (17) with respect to surplus lines  
253 brokers: (A) An examination fee of twenty dollars for each  
254 examination taken, except when a testing service is used, the testing  
255 service shall pay a fee of twenty dollars to the commissioner for each  
256 examination taken by an applicant; and (B) a fee of six hundred

257 twenty-five dollars for each license issued or renewed; (18) with  
258 respect to fraternal agents, a fee of eighty dollars for each license  
259 issued or renewed; (19) a fee of twenty-six dollars for each license  
260 certificate requested, whether or not a license has been issued; (20)  
261 with respect to domestic and foreign benefit societies shall pay: (A) For  
262 service of process, fifty dollars for each person or insurer to be served;  
263 (B) for filing a certified copy of its charter or articles of association,  
264 fifteen dollars; (C) for filing the annual report, twenty dollars; and (D)  
265 for filing any additional paper required by law, fifteen dollars; (21)  
266 with respect to foreign benefit societies: (A) For each certificate of  
267 organization or compliance, fifteen dollars; (B) for each certified copy  
268 of permit, fifteen dollars; and (C) for each copy of a report or certificate  
269 of condition of a society to be filed in any other state, fifteen dollars;  
270 (22) with respect to reinsurance intermediaries: A fee of six hundred  
271 twenty-five dollars for each license issued or renewed; (23) with  
272 respect to life settlement providers: (A) A filing fee of twenty-six  
273 dollars for each initial application for a license made pursuant to  
274 section 38a-465a; and (B) a fee of forty dollars for each license issued or  
275 renewed; (24) with respect to life settlement brokers: (A) A filing fee of  
276 twenty-six dollars for each initial application for a license made  
277 pursuant to section 38a-465a; and (B) a fee of forty dollars for each  
278 license issued or renewed; (25) with respect to preferred provider  
279 networks, a fee of two thousand seven hundred fifty dollars for each  
280 license issued or renewed; (26) with respect to rental companies, as  
281 defined in section 38a-799, a fee of eighty dollars for each permit  
282 issued or renewed; (27) with respect to medical discount plan  
283 organizations licensed under section 38a-479rr, a fee of six hundred  
284 twenty-five dollars for each license issued or renewed; (28) with  
285 respect to pharmacy benefits managers, an application fee of one  
286 hundred dollars for each registration issued or renewed; (29) with  
287 respect to captive insurance companies, as defined in section 38a-91aa,  
288 a fee of three hundred seventy-five dollars for each license issued or  
289 renewed; [and] (30) with respect to each duplicate license issued a fee  
290 of fifty dollars for each license issued; and (31) a filing fee of two  
291 thousand five hundred dollars for each statement of acquisition of

292 control of a domestic insurance company filed pursuant to section 38a-  
293 130.

294 Sec. 4. Section 38a-14a of the general statutes is repealed and the  
295 following is substituted in lieu thereof (*Effective October 1, 2010*):

296 (a) Subject to the limitation contained in this section and in addition  
297 to the powers which the Insurance Commissioner has under sections  
298 38a-14 and 38a-15, as amended by this act, relating to the examination  
299 of insurance companies and health care centers doing business in this  
300 state, the commissioner shall have the power to order any insurance  
301 company registered under section 38a-135 or health care center to  
302 produce such records, books or other information in the possession of  
303 the insurance company or the health care center or its affiliates as are  
304 reasonably necessary to ascertain the financial condition of such  
305 insurance company or health care center or to determine compliance  
306 with sections 38a-129 to 38a-140, inclusive. In the event such insurance  
307 company or health care center fails to comply with such order, the  
308 commissioner shall have the power to examine any such affiliate to  
309 obtain such information.

310 (b) The commissioner may engage the services of attorneys,  
311 actuaries, accountants and other experts not otherwise a part of the  
312 commissioner's staff, at the registered insurance company's or health  
313 care center's expense, as shall be reasonably necessary to assist in the  
314 conduct of the examination under subsection (a) of this section. All  
315 persons so engaged shall be under the direction and control of the  
316 commissioner and shall act in a purely advisory capacity.

317 (c) Each registered insurance company or health care center  
318 producing for examination records, books and papers pursuant to  
319 subsection (a) of this section shall be liable for and shall pay the  
320 expense of such examination in accordance with sections 38a-14 and  
321 38a-15, as amended by this act.

322 Sec. 5. Section 38a-15 of the general statutes is repealed and the  
323 following is substituted in lieu thereof (*Effective October 1, 2010*):

324 (a) The commissioner shall, as often as [he] the commissioner deems  
325 it expedient, undertake a market conduct examination of the affairs of  
326 any insurance company, health care center or fraternal benefit society  
327 doing business in this state.

328 (b) To carry out the examinations under this section, the  
329 commissioner may appoint, as market conduct examiners, one or more  
330 competent persons [, not officers] who shall not be officers of, or  
331 connected with or interested in any insurance company, health care  
332 center or fraternal benefit society, other than as a policyholder. In  
333 conducting the examination, the commissioner, [his] the  
334 commissioner's actuary or any examiner authorized by the  
335 commissioner may examine, under oath, the officers and agents of  
336 such an insurance company, health care center or fraternal benefit  
337 society and all persons deemed to have material information regarding  
338 the company's, center's or society's property or business. Each such  
339 company, center or society, its officers and agents, shall produce the  
340 books and papers, in its or their possession, relating to its business or  
341 affairs, and any other person may be required to produce any book or  
342 paper [, in his] in such person's custody [,] deemed to be relevant to the  
343 examination, for the inspection of the commissioner, [his] the  
344 commissioner's actuary or examiners, when required. The officers and  
345 agents of the company, center or association shall facilitate the  
346 examination and aid the examiners in making the same so far as it is in  
347 their power to do so.

348 (c) Each market conduct examiner shall make a full and true report  
349 of each market conduct examination made by [him] such examiner,  
350 which shall comprise only facts appearing upon the books, papers,  
351 records or documents of the examined company, center or society or  
352 ascertained from the sworn testimony of its officers or agents or of  
353 other persons examined under oath concerning its affairs. The  
354 examiner's report shall be presumptive evidence of the facts therein  
355 stated in any action or proceeding in the name of the state against the  
356 company, center or society, its officers or agents. [The] Before filing  
357 such report, the commissioner shall grant a hearing to the company,

358 center or society examined, [before filing any such report,] and may  
359 withhold any such report from public inspection for such time as [he]  
360 the commissioner deems proper. The commissioner may, if [he] said  
361 commissioner deems it in the public interest, publish any such report,  
362 or the result of any such examination contained therein, in one or more  
363 newspapers of the state.

364 [(d) All the expense of any examination made under the authority of  
365 this section, other than examinations of domestic insurance companies,  
366 shall be paid by the company, center or society examined, and  
367 domestic insurance companies and other domestic entities examined  
368 outside the state shall pay the traveling and maintenance expenses of  
369 examiners.]

370 (d) (1) The commissioner may engage the services of attorneys,  
371 appraisers, independent actuaries, independent certified public  
372 accountants or other professionals and specialists to assist in  
373 conducting the examinations under this section as examiners, the cost  
374 of which shall be borne by the company that is the subject of the  
375 examination.

376 (2) No cause of action shall arise nor shall any liability be imposed  
377 against the commissioner, the commissioner's authorized  
378 representatives or any examiner appointed by the commissioner for  
379 any statements made or conduct performed in good faith while  
380 carrying out the provisions of this section.

381 (3) No cause of action shall arise nor shall any liability be imposed  
382 against any person for the act of communicating or delivering  
383 information or data to the commissioner or the commissioner's  
384 authorized representative or examiner pursuant to an examination  
385 made under this section, if such act of communication or delivery was  
386 performed in good faith and without fraudulent intent or the intent to  
387 deceive.

388 (4) This section shall not abrogate or modify any common law or  
389 statutory privilege or immunity heretofore enjoyed by any person

390 identified in subdivision (2) of this subsection.

391 (5) A person identified in subdivision (2) of this subsection shall be  
392 entitled to an award of attorney's fees and costs if such person is the  
393 prevailing party in a civil cause of action for libel, slander or any other  
394 relevant tort arising out of activities in carrying out the provisions of  
395 this section and the party bringing the action was not substantially  
396 justified in doing so. For the purposes of this section, a proceeding is  
397 "substantially justified" if it had a reasonable basis in law or fact at the  
398 time that it was initiated.

399 (e) Notwithstanding subdivision (1) of subsection (d) of this section,  
400 no domestic insurance company or other domestic entity subject to  
401 examination under this section shall pay, as costs associated with the  
402 examination, the salaries, fringe benefits, and travel and maintenance  
403 expenses of examining personnel of the Insurance Department  
404 engaged in such examination if such domestic company or entity is  
405 otherwise liable to an assessment levied under section 38a-47, except  
406 that a domestic insurance company or other domestic entity shall pay  
407 the traveling and maintenance expenses of examining personnel of the  
408 Insurance Department when such company or entity is examined  
409 outside the state.

410 (f) Nothing in this section shall be construed to prevent or prohibit  
411 the commissioner from disclosing the content of an examination  
412 report, preliminary examination report or results, or any matter  
413 relating thereto, to the Insurance Department of this or any other state  
414 or country, or to law enforcement officials of this or any other state or  
415 to any agency of the federal government at any time, as long as such  
416 agency or office receiving the report or matters relating thereto agrees  
417 in writing to hold such report or matters confidential.

418 (g) All working papers, recorded information, documents and  
419 copies thereof produced by, obtained by or disclosed to the  
420 commissioner or any other person in the course of an examination  
421 made under this section shall be given confidential treatment, shall not  
422 be subject to subpoena and shall not be made public by the

423 commissioner or any other person, except to the extent provided in  
424 subsection (f) of this section. Access to such working papers, recorded  
425 information, documents and copies may be granted by the  
426 commissioner to the National Association of Insurance Commissioners  
427 as long as it agrees, in writing, to hold such working papers, recorded  
428 information, documents and copies confidential.

429 Sec. 6. Subdivision (1) of subsection (d) of section 38a-91bb of the  
430 general statutes is repealed and the following is substituted in lieu  
431 thereof (*Effective October 1, 2010*):

432 (d) (1) Each captive insurance company shall pay to the  
433 commissioner a nonrefundable fee of eight hundred dollars for  
434 examining, investigating and processing its application for a license. [,  
435 and the] The commissioner may retain legal, financial and examination  
436 services from outside the department for the licensing and financial  
437 oversight of a captive insurance company, the reasonable cost of which  
438 may be charged against [the applicant] such company. The provisions  
439 of subdivisions (2) to (5), inclusive, of subsection (k) of section 38a-14  
440 shall apply to [examinations, investigations and processing conducted  
441 under] the services retained pursuant to this [section] subsection.

442 Sec. 7. Subsection (g) of section 38a-91hh of the 2010 supplement to  
443 the general statutes is repealed and the following is substituted in lieu  
444 thereof (*Effective from passage*):

445 (g) Nothing contained in this section shall prevent or be construed  
446 as prohibiting the commissioner from disclosing the content of an  
447 examination report, preliminary examination report or results, or any  
448 matter relating to such report to (1) the [Insurance Department]  
449 insurance regulatory officials of this or any other state or country, (2)  
450 law enforcement officials of this or any other state, or (3) any agency of  
451 this or any other state or of the federal government at any time, so long  
452 as such agency or office receiving the report or matters relating to such  
453 report agrees, in writing, that such documents shall be confidential.

454 Sec. 8. Section 38a-91nn of the 2010 supplement to the general

455 statutes is repealed and the following is substituted in lieu thereof  
456 (*Effective from passage and applicable to calendar years commencing on and*  
457 *after January 1, 2010*):

458 (a) Each captive insurance company shall pay to the Commissioner  
459 of Revenue Services, [in the month of February of each year] on or  
460 before March first, annually, a tax at the rate of thirty-eight hundredths  
461 of one per cent on the first twenty million dollars and two hundred  
462 eighty-five thousandths of one per cent on the next twenty million  
463 dollars and nineteen hundredths of one per cent on the next twenty  
464 million dollars and seventy-two thousandths of one per cent on each  
465 dollar thereafter, on the direct premiums collected or contracted for on  
466 policies or contracts of insurance written by the captive insurance  
467 company during the year ending December thirty-first next preceding,  
468 after deducting from the direct premiums subject to the tax the  
469 amounts paid to policyholders as return premiums which shall include  
470 dividends on unabsorbed premiums or premium deposits returned or  
471 credited to policyholders, except that no tax shall be due or payable as  
472 to considerations received for annuity contracts.

473 (b) The annual minimum aggregate tax to be paid by a captive  
474 insurance company calculated under subsection (a) of this section shall  
475 be seven thousand five hundred dollars, and the annual maximum  
476 aggregate tax shall be two hundred thousand dollars.

477 (c) [A captive insurance company failing to file returns as required  
478 in this section or failing to pay within the time required all taxes  
479 assessed by this section shall be subject to penalty under section 12-  
480 229.] The provisions of sections 12-204, 12-204d, 12-204g and 12-205 to  
481 12-208, inclusive, shall apply to sections 38a-91aa to 38a-91qq,  
482 inclusive, as amended by this act, in the same manner and with the  
483 same force and effect as if the language of sections 12-204, 12-204d, 12-  
484 204g and 12-205 to 12-208, inclusive, had been incorporated in full into  
485 this section and had expressly referred to the tax due under this  
486 section, except to the extent such language is inconsistent with a  
487 provision of sections 38a-91aa to 38a-91qq, inclusive, as amended by

488 this act.

489 (d) Two or more captive insurance companies under common  
490 ownership and control shall be taxed as though they were a single  
491 captive insurance company.

492 (e) For the purposes of this section common ownership and control  
493 means:

494 (1) In the case of stock corporations, the direct or indirect ownership  
495 of eighty per cent or more of the outstanding voting stock of two or  
496 more corporations by the same shareholder or shareholders; and

497 (2) In the case of mutual or nonprofit corporations, the direct or  
498 indirect ownership of eighty per cent or more of the surplus and the  
499 voting power of two or more corporations by the same member or  
500 members.

501 (f) The tax provided for in this section shall constitute all taxes  
502 collectible under the laws of this state from any captive insurance  
503 company, and no other occupation tax or other taxes shall be levied or  
504 collected from any captive insurance company by the state or any  
505 county, city or municipality within this state, except taxes on real and  
506 personal property used in the production of income.

507 (g) The tax provided for in this section shall be calculated on an  
508 annual basis, notwithstanding policies or contracts of insurance or  
509 contracts of reinsurance issued on a multiyear basis. In the case of  
510 multiyear policies or contracts, the premium shall be prorated for  
511 purposes of determining the tax under this section.

512 Sec. 9. Subparagraph (B) of subdivision (1) of section 38a-92a of the  
513 general statutes is repealed and the following is substituted in lieu  
514 thereof (*Effective October 1, 2010*):

515 (B) "Financial guaranty insurance" shall not include:

516 (i) Insurance of any loss resulting from any event described in

517 subparagraph (A) of this subdivision if the loss is payable only upon  
518 the occurrence of any of the following, as specified in a surety bond,  
519 insurance policy or indemnity contract: A fortuitous physical event; a  
520 failure of or deficiency in the operation of equipment; or an inability to  
521 extract or recover a natural resource;

522 (ii) Surety insurance, defined as insurance: Guaranteeing the fidelity  
523 of persons holding positions of public or private trusts; indemnifying  
524 financial institutions against loss of moneys, securities, negotiable  
525 instruments and other tangible items of personal property caused by  
526 larceny, misplacement, destruction or other stated perils; insuring  
527 against loss caused by forgery of signatures on, or alterations of  
528 specified documents, instruments and papers; becoming surety on or  
529 guaranteeing the performance of a bond which shall not exceed a  
530 period greater than five years, that guarantees the payment of a  
531 premium, deductible, or self-insured retention to an insurer issuing a  
532 workers' compensation or liability policy; insuring deposits in financial  
533 institutions to the extent of the excess over the amount insured by the  
534 Federal Deposit Insurance Corporation; guaranteeing the performance  
535 of contracts for services, including a bid, payment or performance  
536 bond where the bond is guaranteeing the execution of any contract  
537 other than a contract of indebtedness or other monetary obligation;  
538 and guaranteeing or otherwise becoming surety for the performance of  
539 any lawful contract, not specifically provided for in this subdivision,  
540 except any insurance contract which constitutes either mortgage  
541 guaranty insurance or financial guaranty insurance, as defined in  
542 subparagraph (A) of this subdivision;

543 (iii) Credit unemployment insurance, defined as insurance on a  
544 debtor in connection with a specific loan or other credit transaction, to  
545 provide payments to a creditor in the event of unemployment of the  
546 debtor for the installments or other periodic payments becoming due  
547 while a debtor is unemployed;

548 (iv) Credit insurance indemnifying a manufacturer, merchant or  
549 educational institution which extends credit against loss or damage

550 resulting from nonpayment of debts owed to such entity for goods or  
551 services provided in the normal course of business;

552 (v) Guaranteed investment contracts issued by a life insurance  
553 company which provides that the life insurer will make specified  
554 payments in exchange for specific premiums or contributions;

555 (vi) Mortgage guaranty insurance, defined as insurance against  
556 financial loss by reason of the nonpayment of principal, interest and  
557 other sums agreed to be paid under the terms of any note or bond or  
558 other evidence of indebtedness secured by a mortgage, deed of trust or  
559 other instrument constituting a first lien or charge on residential real  
560 estate consisting of less than five units;

561 (vii) Indemnity contracts or similar guaranties, to the extent that  
562 they are not otherwise limited or proscribed by sections 38a-92 to 38a-  
563 92n, inclusive, in which a life insurer does any of the following:  
564 Guarantees its obligations or indebtedness or the obligations or  
565 indebtedness of a subsidiary, as defined in section 38a-1, other than a  
566 financial guaranty insurance corporation, provided: To the extent that  
567 any such obligations or indebtedness are backed by specific assets,  
568 those assets shall be at all times owned by the life insurer or the  
569 subsidiary, and in the case of the guaranty of the obligations or  
570 indebtedness of the subsidiary that are not backed by specific assets of  
571 the life insurer, the guaranty terminates once the subsidiary ceases to  
572 be a subsidiary; guarantees obligations or indebtedness, including the  
573 obligation to substitute assets where appropriate, with respect to  
574 specific assets acquired by a life insurer in the course of normal  
575 investment activities and not for the purpose of resale with credit  
576 enhancement or guarantees obligations or indebtedness acquired by a  
577 subsidiary, provided the assets acquired pursuant to this  
578 subparagraph have been either acquired by a special purpose entity,  
579 whose sole purpose is to acquire specific assets of the life insurer or the  
580 subsidiary and issue securities or participation certificates backed by  
581 the assets, or sold to an independent third party, or guarantees  
582 obligations or indebtedness of an employee or agent of the life insurer;

583 (viii) Any cramdown bond or mortgage repurchase bond, as those  
584 phrases are used by nationally recognized rating agencies in respect to  
585 mortgage-backed securities;

586 (ix) Residual value insurance, defined as insurance issued in  
587 connection with a lease or contract which sets forth a specific  
588 termination value at the end of the term of the lease or contract for the  
589 property covered by the lease or contract and which insures against  
590 loss of economic value, other than loss due to physical damage, of  
591 tangible personal property, real property and improvements thereto;

592 (x) Any letter of credit or similar transaction effected by a bank,  
593 trust company or savings association;

594 (xi) Accumulation fund arrangements of any life insurance contract  
595 or annuity contract made pursuant to section 38a-460, or any funding  
596 agreements made pursuant to section 38a-459; or

597 (xii) Any other form of insurance covering risks that the  
598 commissioner determines to be substantially similar to any of the  
599 foregoing.

600 Sec. 10. Subsection (b) of section 38a-364 of the 2010 supplement to  
601 the general statutes is repealed and the following is substituted in lieu  
602 thereof (*Effective from passage*):

603 (b) Each insurance company that issues private passenger motor  
604 vehicle liability insurance providing the security required by sections  
605 38a-19 and 38a-363 to 38a-388, inclusive, shall issue annually to each  
606 such insured an automobile insurance identification card, in duplicate,  
607 for each insured vehicle, one of which shall be presented to the  
608 commissioner as provided in section 14-12b and the other carried in  
609 the vehicle as provided in section [14-12f] 14-13. Except as provided in  
610 subsection (c) of this section, such card shall be effective for a period of  
611 one year and shall include the name of the insured and insurer, the  
612 policy number, the effective date of coverage, the year, make or model  
613 and vehicle identification number of the insured vehicle and an

614 appropriate space wherein the insured may set forth the year, make or  
615 model and vehicle identification number of any private passenger  
616 motor vehicle that becomes covered as a result of a change in the  
617 covered vehicle during the effective period of the identification card.  
618 When an insured has five or more private passenger motor vehicles  
619 registered in this state, the insurer may use the designation "all owned  
620 vehicles" on each card in lieu of a specific vehicle description. Each  
621 insurance company that delivers, issues for delivery or renews such  
622 private passenger motor vehicle liability insurance in this state on or  
623 after January 1, 2009, shall include on such card, the following notice,  
624 printed in capital letters and boldface type:

625

## NOTICE:

626 YOU HAVE THE RIGHT TO CHOOSE THE LICENSED REPAIR  
627 SHOP WHERE THE DAMAGE TO YOUR MOTOR VEHICLE WILL  
628 BE REPAIRED.

629 Sec. 11. Section 38a-430 of the general statutes is repealed and the  
630 following is substituted in lieu thereof (*Effective October 1, 2010*):

631 (a) No life insurance or annuity policy or contract shall be delivered  
632 or issued for delivery to any person in this state, nor shall any  
633 application, rider or endorsement be used in connection therewith,  
634 until a copy of the form thereof shall have been filed with and  
635 approved by the commissioner. The commissioner shall adopt  
636 regulations in accordance with the provisions of chapter 54,  
637 establishing a procedure for review of such policies. The commissioner  
638 shall issue [an order] a decision disapproving the use of any such form  
639 at any time if it does not comply with the requirements of law, or if it  
640 contains a provision or provisions which are unfair or deceptive or  
641 which encourage misrepresentation of the policy. The commissioner  
642 shall specify the reason for his disapproval. The provisions of section  
643 38a-19 shall apply to any such [order] decision issued by the  
644 commissioner.

645 (b) The commissioner may prescribe requirements for disclosure

646 notices, illustrations or other explanatory materials said commissioner  
647 deems necessary to protect policyholders.

648 [(b)] (c) Nothing in this chapter shall preclude the issuance of a life  
649 insurance contract, including, but not limited to, a long-term care  
650 policy as provided in section 38a-458, which includes an optional  
651 health insurance rider, provided [,] the optional health insurance rider  
652 [must be] is filed with and approved by the Insurance Commissioner  
653 pursuant to section 38a-481, as amended by this act. Any company  
654 offering such policies for sale in this state shall be licensed to sell  
655 health insurance in this state pursuant to the provisions of section 38a-  
656 41.

657 Sec. 12. Subsections (a) to (d), inclusive, of section 38a-481 of the  
658 2010 supplement to the general statutes are repealed and the following  
659 is substituted in lieu thereof (*Effective October 1, 2010*):

660 (a) (1) No individual health insurance policy shall be delivered or  
661 issued for delivery to any person in this state, nor shall any  
662 application, rider or endorsement be used in connection with such  
663 policy, until a copy of the form thereof and of the classification of risks  
664 and the premium rates have been filed with the commissioner. The  
665 commissioner shall adopt regulations, in accordance with chapter 54,  
666 to establish a procedure for reviewing such policies. The commissioner  
667 shall disapprove the use of such form at any time if it does not comply  
668 with the requirements of law, or if it contains a provision or provisions  
669 [which] that are unfair or deceptive or [which] that encourage  
670 misrepresentation of the policy. The commissioner shall notify, in  
671 writing, the insurer [which] that has filed any such form of the  
672 commissioner's disapproval, specifying the reasons for disapproval,  
673 and [ordering] communicating that no such insurer shall deliver or  
674 issue for delivery to any person in this state a policy on or containing  
675 such form. The provisions of section 38a-19 shall apply to such [orders]  
676 notifications of disapprovals.

677 (2) The commissioner may prescribe requirements for disclosure  
678 notices, illustrations or other explanatory materials said commissioner

679 deems necessary to protect policyholders.

680 (b) No rate filed under the provisions of subsection (a) of this  
681 section shall be effective until the expiration of thirty days after it has  
682 been filed or unless sooner approved by the commissioner in  
683 accordance with regulations adopted pursuant to this subsection. The  
684 commissioner shall adopt regulations, in accordance with chapter 54,  
685 to prescribe standards to [insure] ensure that such rates shall not be  
686 excessive, inadequate or unfairly discriminatory. The commissioner  
687 may disapprove such rate within thirty days after it has been filed if it  
688 fails to comply with such standards, except that no rate filed under the  
689 provisions of subsection (a) of this section for any Medicare  
690 supplement policy shall be effective unless approved in accordance  
691 with section 38a-474, as amended by this act.

692 (c) No insurance company, fraternal benefit society, hospital service  
693 corporation, medical service corporation, health care center or other  
694 entity which delivers or issues for delivery in this state any Medicare  
695 supplement policies or certificates shall incorporate in its rates or  
696 determinations to grant coverage for Medicare supplement insurance  
697 policies or certificates any factors or values based on the age, gender,  
698 previous claims history or the medical condition of any person covered  
699 by such policy or certificate. [ , except for plans "H" to "J", inclusive, as  
700 provided in section 38a-495b. In plans "H" to "J", inclusive, previous  
701 claims history and the medical condition of the applicant may be used  
702 in determinations to grant coverage under Medicare supplement  
703 policies and certificates issued prior to January 1, 2006.]

704 (d) Rates on a particular policy form [will] shall not be deemed  
705 excessive if the insurer has filed a loss ratio guarantee with the  
706 Insurance Commissioner [which] that meets the requirements of  
707 subsection (e) of this section provided (1) the form of such loss ratio  
708 guarantee has been explicitly approved by the Insurance  
709 Commissioner, and (2) the current expected lifetime loss ratio is not  
710 more than five per cent less than the filed lifetime loss ratio as certified  
711 by an actuary. The insurer shall withdraw the policy form if the

712 commissioner determines that the lifetime loss ratio will not be met.  
713 Rates also [will] shall not be deemed excessive if the insurer complies  
714 with the terms of the loss ratio guarantee. The Insurance  
715 Commissioner may adopt regulations, in accordance with chapter 54,  
716 to [assure] ensure that the use of a loss ratio guarantee does not  
717 constitute an unfair practice.

718 Sec. 13. Subsection (b) of section 38a-495b of the general statutes is  
719 repealed and the following is substituted in lieu thereof (*Effective from*  
720 *passage*):

721 (b) In accordance with the regulations adopted pursuant to section  
722 38a-495a, on and after July 1, 2005, there [are] shall be standardized  
723 Medicare supplement insurance policies or certificates as designated  
724 [as plans "A" to "L", inclusive] by the Centers for Medicare and  
725 Medicaid Services.

726 Sec. 14. Section 38a-513 of the general statutes is repealed and the  
727 following is substituted in lieu thereof (*Effective October 1, 2010*):

728 (a) (1) No group health insurance policy, as defined by the  
729 commissioner, or certificate shall be issued or delivered in this state  
730 unless a copy of the form for such policy or certificate has been  
731 submitted to and approved by the commissioner under the regulations  
732 adopted pursuant to this section. The commissioner shall adopt  
733 regulations, in accordance with chapter 54, concerning the provisions,  
734 submission and approval of such policies and certificates and  
735 establishing a procedure for reviewing such policies and certificates. [If  
736 the commissioner issues an order disapproving the use of such form,  
737 the] The commissioner shall disapprove the use of such form at any  
738 time if it does not comply with the requirements of law, or if it  
739 contains a provision or provisions that are unfair or deceptive or that  
740 encourage misrepresentation of the policy. The commissioner shall  
741 notify, in writing, the insurer that has filed any such form of the  
742 commissioner's disapproval, specifying the reasons for disapproval,  
743 and communicating that no such insurer shall deliver or issue for  
744 delivery to any person in this state a policy on or containing such form.

745 The provisions of section 38a-19 shall apply to such [order]  
746 notifications of disapprovals.

747 (2) The commissioner may prescribe requirements for disclosure  
748 notices, illustrations or other explanatory materials said commissioner  
749 deems necessary to protect policyholders.

750 (b) No insurance company, fraternal benefit society, hospital service  
751 corporation, medical service corporation, health care center or other  
752 entity [which] that delivers or issues for delivery in this state any  
753 Medicare supplement policies or certificates shall incorporate in its  
754 rates or determinations to grant coverage for Medicare supplement  
755 insurance policies or certificates any factors or values based on the age,  
756 gender, previous claims history or the medical condition of any person  
757 covered by such policy or certificate. [, except for plans "H" to "J",  
758 inclusive, as provided in section 38a-495b. In plans "H" to "J", inclusive,  
759 previous claims history and the medical condition of the applicant may  
760 be used in determinations to grant coverage under Medicare  
761 supplement policies and certificates issued prior to January 1, 2006.]

762 (c) Nothing in this chapter shall preclude the issuance of a group  
763 health insurance policy which includes an optional life insurance rider,  
764 provided the optional life insurance rider must be filed with and  
765 approved by the Insurance Commissioner pursuant to section 38a-430,  
766 as amended by this act. Any company offering such policies for sale in  
767 this state shall be licensed to sell life insurance in this state pursuant to  
768 the provisions of section 38a-41.

769 (d) Not later than January 1, 2009, the commissioner shall adopt  
770 regulations, in accordance with chapter 54, to establish minimum  
771 standards for benefits in group specified disease policies, certificates,  
772 riders, endorsements and benefits.

773 Sec. 15. Subdivision (15) of section 38a-816 of the general statutes is  
774 repealed and the following is substituted in lieu thereof (*Effective*  
775 *October 1, 2010*):

776 (15) (A) Failure by an insurer, or any other entity responsible for  
777 providing payment to a health care provider pursuant to an insurance  
778 policy, to pay accident and health claims, including, but not limited to,  
779 claims for payment or reimbursement to health care providers, within  
780 the time periods set forth in subparagraph (B) of this subdivision,  
781 unless the Insurance Commissioner determines that a legitimate  
782 dispute exists as to coverage, liability or damages or that the claimant  
783 has fraudulently caused or contributed to the loss. Any insurer, or any  
784 other entity responsible for providing payment to a health care  
785 provider pursuant to an insurance policy, who fails to pay such a claim  
786 or request within the time periods set forth in subparagraph (B) of this  
787 subdivision shall pay the claimant or health care provider the amount  
788 of such claim plus interest at the rate of fifteen per cent per annum, in  
789 addition to any other penalties which may be imposed pursuant to  
790 sections 38a-11, as amended by this act, 38a-25, 38a-41 to 38a-53,  
791 inclusive, 38a-57 to 38a-60, inclusive, 38a-62 to 38a-64, inclusive, 38a-  
792 76, 38a-83, 38a-84, 38a-117 to 38a-124, inclusive, 38a-129 to 38a-140,  
793 inclusive, 38a-146 to 38a-155, inclusive, 38a-283, 38a-288 to 38a-290,  
794 inclusive, 38a-319, 38a-320, 38a-459, 38a-464, 38a-815 to 38a-819,  
795 inclusive, 38a-824 to 38a-826, inclusive, and 38a-828 to 38a-830,  
796 inclusive. Whenever the interest due a claimant or health care provider  
797 pursuant to this section is less than one dollar, the insurer shall deposit  
798 such amount in a separate interest-bearing account in which all such  
799 amounts shall be deposited. At the end of each calendar year each such  
800 insurer shall donate such amount to The University of Connecticut  
801 Health Center.

802 (B) Each insurer, or other entity responsible for providing payment  
803 to a health care provider pursuant to an insurance policy subject to this  
804 section, shall pay claims not later than forty-five days after receipt by  
805 the insurer of the claimant's proof of loss form or the health care  
806 provider's request for payment filed in accordance with the insurer's  
807 practices or procedures, except that when there is a deficiency in the  
808 information needed for processing a claim, as determined in  
809 accordance with section 38a-477, the insurer shall (i) send written  
810 notice to the claimant or health care provider, as the case may be, of all

811 alleged deficiencies in information needed for processing a claim not  
812 later than thirty days after the insurer receives a claim for payment or  
813 reimbursement under the contract, and (ii) pay claims for payment or  
814 reimbursement under the contract not later than thirty days after the  
815 insurer receives the information requested.

816 (C) As used in this subdivision, "health care provider" means (i) a  
817 person licensed to provide health care services under chapter 368d,  
818 chapter 368v, chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a  
819 to 384c, inclusive, or chapter 400j, and (ii) a person who holds an  
820 equivalent license from any other state.

821 Sec. 16. Subsection (a) of section 38a-478n of the 2010 supplement to  
822 the general statutes is repealed and the following is substituted in lieu  
823 thereof (*Effective from passage*):

824 (a) Any enrollee, or any provider acting on behalf of an enrollee  
825 with the enrollee's consent, who has exhausted the internal  
826 mechanisms provided by a managed care organization, health insurer  
827 or utilization review company to appeal the denial of a claim based on  
828 medical necessity or a determination not to certify an admission,  
829 service, procedure or extension of stay, regardless of whether such  
830 determination was made before, during or after the admission, service,  
831 procedure or extension of stay, may appeal such denial or  
832 determination to the commissioner. As used in this section and section  
833 38a-478m, "health insurer" means any entity, other than a managed  
834 care organization that delivers, issues for delivery, renews, amends or  
835 continues an individual or group health insurance plan in this state  
836 providing coverage of the type specified in subdivision (1), (2), (4),  
837 (10), (11), (12), [and] (13) and (16) of section 38a-469, and "enrollee"  
838 means a person who has contracted for or who participates in coverage  
839 under an individual or group health insurance plan or a managed care  
840 plan for such person or such person's eligible dependents.

841 Sec. 17. Section 2 of public act 09-179 is repealed and the following is  
842 substituted in lieu thereof (*Effective from passage*):

843 The commissioner shall carry out a review as set forth in section 1 of  
844 [this act] public act 09-179 of statutorily mandated health benefits  
845 existing on or effective on July 1, 2009. The commissioner shall submit,  
846 in accordance with section 11-4a of the general statutes, the findings to  
847 the joint standing committee of the General Assembly having  
848 cognizance of matters relating to insurance not later than January 1,  
849 [2010] 2011.

850 Sec. 18. Subsection (b) of section 38a-473 of the general statutes is  
851 repealed and the following is substituted in lieu thereof (*Effective from*  
852 *passage*):

853 (b) No insurance company, fraternal benefit society, hospital service  
854 corporation, medical service corporation, health care center or other  
855 entity which delivers or issues for delivery in this state any Medicare  
856 supplement policies or certificates shall incorporate in its rates or  
857 determinations to grant coverage for Medicare supplement insurance  
858 policies or certificates any factors or values based on the age, gender,  
859 previous claims history or the medical condition of any person covered  
860 by such policy or certificate. [ , except for plans "H" to "J", inclusive, as  
861 provided in section 38a-495b. In plans "H" to "J", inclusive, previous  
862 claims history and the medical condition of the applicant may be used  
863 in determinations to grant coverage under Medicare supplement  
864 policies and certificates issued prior to January 1, 2006.]

865 Sec. 19. Subsection (b) of section 38a-474 of the general statutes is  
866 repealed and the following is substituted in lieu thereof (*Effective from*  
867 *passage*):

868 (b) No insurance company, fraternal benefit society, hospital service  
869 corporation, medical service corporation, health care center or other  
870 entity which delivers or issues for delivery in this state any Medicare  
871 supplement policies or certificates shall incorporate in its rates or  
872 determinations to grant coverage for Medicare supplement insurance  
873 policies or certificates any factors or values based on the age, gender,  
874 previous claims history or the medical condition of the person covered  
875 by such policy or certificate. [ , except for plans "H" to "J", inclusive, as

876 provided in section 38a-495b. In plans "H" to "J", inclusive, previous  
877 claims history and the medical condition of the applicant may be used  
878 in determinations to grant coverage under Medicare supplement  
879 policies and certificates issued prior to January 1, 2006.]

880 Sec. 20. Subsections (a) and (b) of section 38a-495c of the general  
881 statutes are repealed and the following is substituted in lieu thereof  
882 (*Effective from passage*):

883 (a) Each insurance company, fraternal benefit society, hospital  
884 service corporation, medical service corporation, health care center or  
885 other entity in this state, on or after January 1, 1994, which delivers,  
886 issues for delivery, continues or renews any Medicare supplement  
887 insurance policies or certificates shall base the premium rates charged  
888 on a community rate. Such rate shall not be based on age, gender,  
889 previous claims history or the medical condition of the person covered  
890 by such policy or certificate. Except as provided in subsection (c) of  
891 this section, coverage shall not be denied on the basis of age, gender,  
892 previous claim history or the medical condition of the person covered  
893 by such policy or certificate. [ , except for plans "H" to "J", inclusive, as  
894 provided in section 38a-495b. In plans "H" to "J", inclusive, previous  
895 claims history and the medical condition of the applicant may be used  
896 in determinations to grant coverage under Medicare supplement  
897 policies and certificates issued prior to January 1, 2006.]

898 (b) Nothing in this section shall prohibit an insurance company,  
899 fraternal benefit society, hospital service corporation, medical service  
900 corporation, health care center or other entity in this state issuing  
901 Medicare supplement insurance policies or certificates from using its  
902 usual and customary underwriting procedures, provided no such  
903 company, society, corporation, center or other entity shall issue a  
904 Medicare supplement policy or certificate based on the age, gender,  
905 previous claims history or the medical condition of the applicant. [ ,  
906 except that the previous claims history and the medical condition of  
907 the applicant may be used in determinations to grant coverage under  
908 Medicare supplement policies and certificates issued prior to January

909 1, 2006, for plans "H" to "J", inclusive.]

910 Sec. 21. Subdivision (1) of subsection (k) of section 38a-865 of the  
911 general statutes is repealed and the following is substituted in lieu  
912 thereof (*Effective from passage*):

913 (k) (1) A person receiving benefits under sections 38a-858 to 38a-875,  
914 inclusive, whether the benefits are payments of or on account of  
915 contractual obligations, continuation of coverage or provision of  
916 substitute or alternative coverages, shall be deemed to have assigned  
917 (A) the rights under the covered policy or contract to the association to  
918 the extent of the benefits received under sections 38a-858 to 38a-875,  
919 inclusive, and (B) any [causes] cause of action against any person for  
920 losses arising under, resulting from or otherwise relating to, the  
921 covered policy or contract to the association to the extent of the  
922 benefits received because of sections 38a-858 to 38a-875, inclusive. The  
923 association may require an assignment to it of such rights or cause of  
924 action by any payee, policy or contract owner, beneficiary, insured or  
925 annuitant as a condition precedent to the receipt of any right or  
926 benefits under sections 38a-858 to 38a-875, inclusive, upon the person.  
927 The provisions of sections 52-225g to 52-225l, inclusive, shall not apply  
928 to such rights or cause of action assigned to the association pursuant to  
929 this subsection.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2010</i>	38a-8(d)
Sec. 2	<i>from passage</i>	38a-9
Sec. 3	<i>October 1, 2010</i>	38a-11(a)
Sec. 4	<i>October 1, 2010</i>	38a-14a
Sec. 5	<i>October 1, 2010</i>	38a-15
Sec. 6	<i>October 1, 2010</i>	38a-91bb(d)(1)
Sec. 7	<i>from passage</i>	38a-91hh(g)
Sec. 8	<i>from passage and applicable to calendar years commencing on and after January 1, 2010</i>	38a-91nn

Sec. 9	<i>October 1, 2010</i>	38a-92a(1)(B)
Sec. 10	<i>from passage</i>	38a-364(b)
Sec. 11	<i>October 1, 2010</i>	38a-430
Sec. 12	<i>October 1, 2010</i>	38a-481(a) to (d)
Sec. 13	<i>from passage</i>	38a-495b(b)
Sec. 14	<i>October 1, 2010</i>	38a-513
Sec. 15	<i>October 1, 2010</i>	38a-816(15)
Sec. 16	<i>from passage</i>	38a-478n(a)
Sec. 17	<i>from passage</i>	PA 09-179, Sec. 2
Sec. 18	<i>from passage</i>	38a-473(b)
Sec. 19	<i>from passage</i>	38a-474(b)
Sec. 20	<i>from passage</i>	38a-495c(a) and (b)
Sec. 21	<i>from passage</i>	38a-865(k)(1)

**INS**      *Joint Favorable Subst.*

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:**

<b>Agency Affected</b>	<b>Fund-Effect</b>	<b>FY 11 \$</b>	<b>FY 12 \$</b>
Insurance Dept.	GF - Revenue Gain	6,510	10,690

Note: GF=General Fund

**Municipal Impact:** None

### **Explanation**

The bill results in a General Fund revenue gain of \$6,510 in FY 11 and \$10,690 in FY 12. It increases filing fees for arbitration of automobile disputes from \$20 for insurer and claimants to \$100 for insurers and \$50 for claimants, resulting in a net General Fund revenue gain of \$1,510 in FY 11 and \$3,190 in FY 12<sup>1</sup>. It also establishes a \$2,500 filing fee for acquisition of control of a domestic insurance company, which results in a General Fund revenue gain of \$5,000 in FY 11 and \$7,500 in FY 12<sup>2</sup>.

Other provisions of the bill are not anticipated to result in a fiscal impact.

### **The Out Years**

<sup>1</sup> There were 20 automobile insurance arbitrations in 2008 and 22 in 2009, an approximate increase of 10% from one year to the next. It is anticipated that there will be 24 arbitrations in FY 10 and 26 in FY 11. As the bill is effective October 1, 2010, the number of estimated arbitration fees is based on an 8-month average of 17 automobile arbitrations in FY 11. The FY 12 revenue analysis assumes 29 automobile arbitrations in that fiscal year.

<sup>2</sup> This assumes an average of 3 acquisition of control of a domestic insurance company filings, as reported by the Department of Insurance. As the bill is effective October 1, 2010, it is anticipated that there will be 2 acquisition of control of a domestic insurance company filings during the eight-month period in FY 11 and 3 in FY 12.

The annualized ongoing fiscal impact identified above would continue into the future subject to the number of automobile arbitrations and filings for acquisition of control of a domestic insurance company.

**OLR Bill Analysis****sSB 93*****AN ACT CONCERNING REVISIONS TO THE INSURANCE STATUTES.*****SUMMARY:**

This bill makes changes in various insurance statutes. It:

1. expands the list of regulated entities for which the insurance commissioner may hire financial examination consultants to include any entity that must be licensed by, or registered with, the Insurance Department (§§ 1 and 6);
2. increases the filing fee for arbitrating disputes between auto insurers and claimants concerning certain private passenger auto insurance claims from \$20 for both to \$100 for an insurer and \$50 for a claimant (§ 2);
3. amends the statutory description of the Insurance Department to remove obsolete references (§ 2);
4. establishes a \$2,500 fee for filing Form A (i.e., the legally-required statement about acquiring control of a Connecticut insurer) (§ 3);
5. authorizes the commissioner to (a) order a health care center (i.e., HMO) to produce books, records, and other information it or an affiliate has and the department needs to conduct an examination of the company, a power he has with respect to insurers, and (b) examine an HMO's affiliate if the HMO fails to comply with the order (§ 4);
6. requires an HMO to pay costs related to the department's examination of it, including costs to hire consultants to assist

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- with the examination (§ 4);
7. revises the market conduct examination law with respect to costs, immunity, and confidentiality (see MARKET CONDUCT EXAMINATIONS) (§ 5);
  8. allows the commissioner to disclose an examination report of a captive insurance company to any state agency in Connecticut or elsewhere if the agency agrees to keep it confidential (§ 7);
  9. imposes the same tax assessment, collection, payment, and annual return requirements and procedures on captive insurers that apply to all other insurance companies and requires them to pay taxes by March 1 annually, instead of in February (§ 8);
  10. specifies that the department regulates insurance covering bank deposits in excess of the Federal Deposit Insurance Corporation as a surety bond product rather than a financial guaranty (§ 9);
  11. applies the health insurance claim prompt payment requirements (see BACKGROUND) to health care providers licensed in another state, in addition to the Connecticut-licensed providers currently covered, to conform to Attorney General Opinion 2008-15 (§ 15);
  12. extends the external appeal statute to apply to single service ancillary health coverage plans, including dental, vision, and prescription drug plans (§ 16);
  13. delays, from January 1, 2010 to 2011, the deadline for the insurance commissioner's report to the Insurance and Real Estate Committee on the health insurance benefits mandated in Connecticut required by PA 09-179 (§ 17);
  14. specifies that court orders regarding transfer of structured settlements do not apply to insolvency proceedings under the Connecticut Life and Health Insurance Guaranty Association (§ 21); and

15. recharacterizes the commissioner's disapproval of life and health insurance policy and related forms as a decision, rather than an order, but continues to treat the decision as an order for purposes of appeals and hearings related to it (§§ 11 and 12).

The bill authorizes the commissioner to (1) prescribe requirements for disclosure notices, illustrations, and other material he deems necessary and (2) disapprove a group health insurance policy or certificate form at any time if it (a) does not comply with applicable laws, (b) contains unfair or deceptive provisions, or (c) encourages policy misrepresentation (§§ 11, 12, and 14). If the commissioner disapproves a form, he must notify the insurer in writing, specify the reasons for the disapproval, and prohibit the insurer from using the disapproved form (§ 14).

The bill removes obsolete references in the Medicare supplement laws (§§ 12, 13, 18-20) and makes other technical and conforming changes.

EFFECTIVE DATE: October 1, 2010, except for the increased arbitration filing fee, revised department organizational description, captive insurer, external appeal, delay of the PA 09-179 report deadline, guaranty association, and Medicare supplement provisions, which are effective on passage. The captive insurer tax provision is applicable to calendar years beginning on or after January 1, 2010.

## **§ 5 — MARKET CONDUCT EXAMINATIONS**

A market conduct examination is an Insurance Department's audit of a company licensed to do business in Connecticut to determine compliance with applicable state laws and regulations. It is separate and distinct from a financial examination, but may be conducted at the same time.

### **Costs**

By law, the company being examined must pay examination costs. The bill specifies that these include the cost for the department to hire consultants to assist with the examination.

The bill exempts a Connecticut company under examination from paying the salaries, fringe benefits, travel, and maintenance expenses of the department's examining personnel if the company pays assessments under law to the Insurance Department toward the department's operating expenses.

By law, unchanged by the bill, a Connecticut company under examination must pay the examiner's travel and maintenance expenses when the department examines the company outside of Connecticut.

### ***Immunity***

The bill specifies that no cause of action or liability accrues against certain activities of specified people if those activities were performed in good faith.

Specifically, no cause of action or liability accrues against the commissioner, his authorized representatives, or appointed examiners for statements made or conduct performed in good faith while carrying out market conduct action. And no cause of action or liability accrues against any person communicating or delivering information to the commissioner, his representative, or examiner during an examination if the communication or delivery is performed in good faith and without fraudulent intent or the intent to deceive.

If someone files a civil action for libel, slander, or any other relevant tort arising out of examination activities against the commissioner, his authorized representative, or an appointed examiner, the bill entitles the commissioner or other person to an award of attorney's fees and costs if (1) he or she prevails and (2) the party bringing the action was not substantially justified in doing so. The bill defines a proceeding as "substantially justified" if it had a reasonable basis in law or fact when it was initiated.

The bill states that it does not abrogate or modify any common law or statutory privilege or immunity the people mentioned above currently enjoy.

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**Confidentiality**

The bill makes working papers, recorded information, and documents, and copies of these, produced or obtained by, or disclosed to, the commissioner or any other person during a market conduct examination confidential and not subject to subpoena. The bill prohibits the commissioner or any other person from making them public, except the commissioner may grant the National Association of Insurance Commissioners access, if it agrees in writing to keep them confidential.

The bill also authorizes the commissioner to share an examination report, preliminary report or results, or any related matter, with other state, federal, and international regulatory agencies and law enforcement authorities, if the recipient agrees in writing to keep the report or matters confidential.

**BACKGROUND*****Prompt Claim Payment Requirements***

By law, an insurer or other entity responsible for paying health and accident claims must pay a clean claim, including those payable to a health care provider, within 45 days of receiving it (CGS § 38a-816(15)). A claim is considered “clean” if it is submitted with all information required by law (CGS § 38a-477).

If a claim contains a deficiency, the entity must send written notice to the claimant or health care provider, as the case may be, of all alleged deficiencies within 30 days of receiving the claim. The entity must process the claim within 30 days of receiving the corrected claim. The entity must add 15% interest if payment is late.

The prompt pay law defines “health care provider” as a physician, surgeon, chiropractor, natureopath, podiatrist, athletic trainer, physical therapist, occupational therapist, alcohol and drug counselor, radiologist, midwife, nurse, nurse’s aide, dentist, dental hygienist, optometrist, optician, respiratory care practitioner, perfusionist, pharmacist, psychologist, marital and family therapist, clinical social

worker, professional counselor, massage therapist, dietician-nutritionist, acupuncturist, emergency medical service technician (EMT), and licensed health care institution.

Licensed health care institution includes a hospital; residential care home; health care facility for the handicapped; nursing home; rest home; home health care agency; homemaker-home health aide agency; mental health facility; substance abuse treatment facility; student infirmary; an EMT organization; a facility providing services for the prevention, diagnosis, and treatment of human health conditions; and a Medicaid-certified residential facility for the mentally retarded.

### ***Related Bill***

The Insurance and Real Estate Committee reported out sSB 393, which changes the prompt claim payment requirements. Instead of requiring claims to be paid within 45 days, it requires paper claims to be paid within 60 days and electronic claims to be paid within 15 days.

### **COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 19 Nay 0 (03/18/2010)