



Senate

General Assembly

File No. 652

February Session, 2010

Substitute Senate Bill No. 93

Senate, April 28, 2010

The Committee on Judiciary reported through SEN. MCDONALD of the 27th 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2 repealed and the following is substituted in lieu thereof (*Effective*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) No domestic insurance company or other domestic entity subject
371 to examination under this section shall pay, as costs associated with
372 the examination, the salaries, fringe benefits, and traveling and
373 maintenance expenses of examining personnel of the Insurance
374 Department engaged in such examination if such domestic company
375 or entity is otherwise liable to an assessment levied under section 38a-
376 47, except that a domestic insurance company or other domestic entity
377 shall pay the traveling and maintenance expenses of examining
378 personnel of the Insurance Department when such company or entity
379 is examined outside the state.

380 (e) Nothing in this section shall be construed to prevent or prohibit
381 the commissioner from disclosing the content of an examination
382 report, preliminary examination report or results, or any matter
383 relating thereto, to the Insurance Department of this or any other state
384 or country, or to law enforcement officials of this or any other state or
385 to any agency of the federal government at any time, provided such
386 agency or office receiving the report or matters relating thereto agrees
387 in writing to hold such report or matters confidential.

388 (f) All working papers, recorded information, documents and copies
389 thereof produced by, obtained by or disclosed to the commissioner or
390 any other person in the course of an examination made under this

391 section shall be given confidential treatment, shall not be subject to
392 subpoena and shall not be made public by the commissioner or any
393 other person, except to the extent provided in subsection (e) of this
394 section. Access to such working papers, recorded information,
395 documents and copies may be granted by the commissioner to the
396 National Association of Insurance Commissioners, provided it agrees,
397 in writing, to hold such working papers, recorded information,
398 documents and copies confidential.

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400 general statutes is repealed and the following is substituted in lieu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

402 (d) (1) Each captive insurance company shall pay to the
403 commissioner a nonrefundable fee of eight hundred dollars for
404 examining, investigating and processing its application for a license. [
405 and the] The commissioner may retain legal, financial and examination
406 services from outside the department for the licensing and financial
407 oversight of a captive insurance company, the reasonable cost of which
408 may be charged against [the applicant] such company. The provisions
409 of subdivisions (2) to (5), inclusive, of subsection (k) of section 38a-14
410 shall apply to [examinations, investigations and processing conducted
411 under] the services retained pursuant to this [section] subsection.

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

415 (g) Nothing contained in this section shall prevent or be construed
416 as prohibiting the commissioner from disclosing the content of an
417 examination report, preliminary examination report or results, or any
418 matter relating to such report to (1) the [Insurance Department]
419 insurance regulatory officials of this or any other state or country, (2)
420 law enforcement officials of this or any other state, or (3) any agency of
421 this or any other state or of the federal government at any time, so long
422 as such agency or office receiving the report or matters relating to such
423 report agrees, in writing, that such documents shall be confidential.

424 Sec. 8. Section 38a-91nn of the 2010 supplement to the general
425 statutes is repealed and the following is substituted in lieu thereof
426 (*Effective from passage and applicable to calendar years commencing on and*
427 *after January 1, 2010*):

428 (a) Each captive insurance company shall pay to the Commissioner
429 of Revenue Services, [in the month of February of each year] on or
430 before March first, annually, a tax at the rate of thirty-eight hundredths
431 of one per cent on the first twenty million dollars and two hundred
432 eighty-five thousandths of one per cent on the next twenty million
433 dollars and nineteen hundredths of one per cent on the next twenty
434 million dollars and seventy-two thousandths of one per cent on each
435 dollar thereafter, on the direct premiums collected or contracted for on
436 policies or contracts of insurance written by the captive insurance
437 company during the year ending December thirty-first next preceding,
438 after deducting from the direct premiums subject to the tax the
439 amounts paid to policyholders as return premiums which shall include
440 dividends on unabsorbed premiums or premium deposits returned or
441 credited to policyholders, except that no tax shall be due or payable as
442 to considerations received for annuity contracts.

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

447 (c) [A captive insurance company failing to file returns as required
448 in this section or failing to pay within the time required all taxes
449 assessed by this section shall be subject to penalty under section 12-
450 229.] The provisions of sections 12-204, 12-204d, 12-204g and 12-205 to
451 12-208, inclusive, shall apply to sections 38a-91aa to 38a-91qq,
452 inclusive, as amended by this act, in the same manner and with the
453 same force and effect as if the language of sections 12-204, 12-204d, 12-
454 204g and 12-205 to 12-208, inclusive, had been incorporated in full into
455 this section and had expressly referred to the tax due under this
456 section, except to the extent such language is inconsistent with a

457 provision of sections 38a-91aa to 38a-91qq, inclusive, as amended by
458 this act.

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

462 (e) For the purposes of this section common ownership and control
463 means:

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

467 (2) In the case of mutual or nonprofit corporations, the direct or
468 indirect ownership of eighty per cent or more of the surplus and the
469 voting power of two or more corporations by the same member or
470 members.

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

477 (g) The tax provided for in this section shall be calculated on an
478 annual basis, notwithstanding policies or contracts of insurance or
479 contracts of reinsurance issued on a multiyear basis. In the case of
480 multiyear policies or contracts, the premium shall be prorated for
481 purposes of determining the tax under this section.

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

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

486 (i) Insurance of any loss resulting from any event described in
487 subparagraph (A) of this subdivision if the loss is payable only upon
488 the occurrence of any of the following, as specified in a surety bond,
489 insurance policy or indemnity contract: A fortuitous physical event; a
490 failure of or deficiency in the operation of equipment; or an inability to
491 extract or recover a natural resource;

492 (ii) Surety insurance, defined as insurance: Guaranteeing the fidelity
493 of persons holding positions of public or private trusts; indemnifying
494 financial institutions against loss of moneys, securities, negotiable
495 instruments and other tangible items of personal property caused by
496 larceny, misplacement, destruction or other stated perils; insuring
497 against loss caused by forgery of signatures on, or alterations of
498 specified documents, instruments and papers; becoming surety on or
499 guaranteeing the performance of a bond which shall not exceed a
500 period greater than five years, that guarantees the payment of a
501 premium, deductible, or self-insured retention to an insurer issuing a
502 workers' compensation or liability policy; insuring deposits in financial
503 institutions to the extent of the excess over the amount insured by the
504 Federal Deposit Insurance Corporation; guaranteeing the performance
505 of contracts for services, including a bid, payment or performance
506 bond where the bond is guaranteeing the execution of any contract
507 other than a contract of indebtedness or other monetary obligation;
508 and guaranteeing or otherwise becoming surety for the performance of
509 any lawful contract, not specifically provided for in this subdivision,
510 except any insurance contract which constitutes either mortgage
511 guaranty insurance or financial guaranty insurance, as defined in
512 subparagraph (A) of this subdivision;

513 (iii) Credit unemployment insurance, defined as insurance on a
514 debtor in connection with a specific loan or other credit transaction, to
515 provide payments to a creditor in the event of unemployment of the
516 debtor for the installments or other periodic payments becoming due
517 while a debtor is unemployed;

518 (iv) Credit insurance indemnifying a manufacturer, merchant or

519 educational institution which extends credit against loss or damage
520 resulting from nonpayment of debts owed to such entity for goods or
521 services provided in the normal course of business;

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

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

531 (vii) Indemnity contracts or similar guaranties, to the extent that
532 they are not otherwise limited or proscribed by sections 38a-92 to 38a-
533 92n, inclusive, in which a life insurer does any of the following:
534 Guarantees its obligations or indebtedness or the obligations or
535 indebtedness of a subsidiary, as defined in section 38a-1, other than a
536 financial guaranty insurance corporation, provided: To the extent that
537 any such obligations or indebtedness are backed by specific assets,
538 those assets shall be at all times owned by the life insurer or the
539 subsidiary, and in the case of the guaranty of the obligations or
540 indebtedness of the subsidiary that are not backed by specific assets of
541 the life insurer, the guaranty terminates once the subsidiary ceases to
542 be a subsidiary; guarantees obligations or indebtedness, including the
543 obligation to substitute assets where appropriate, with respect to
544 specific assets acquired by a life insurer in the course of normal
545 investment activities and not for the purpose of resale with credit
546 enhancement or guarantees obligations or indebtedness acquired by a
547 subsidiary, provided the assets acquired pursuant to this
548 subparagraph have been either acquired by a special purpose entity,
549 whose sole purpose is to acquire specific assets of the life insurer or the
550 subsidiary and issue securities or participation certificates backed by
551 the assets, or sold to an independent third party, or guarantees

552 obligations or indebtedness of an employee or agent of the life insurer;

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

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

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

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

567 (xii) Any other form of insurance covering risks that the
568 commissioner determines to be substantially similar to any of the
569 foregoing.

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

573 (b) Each insurance company that issues private passenger motor
574 vehicle liability insurance providing the security required by sections
575 38a-19 and 38a-363 to 38a-388, inclusive, shall issue annually to each
576 such insured an automobile insurance identification card, in duplicate,
577 for each insured vehicle, one of which shall be presented to the
578 commissioner as provided in section 14-12b and the other carried in
579 the vehicle as provided in section [14-12f] 14-13. Except as provided in
580 subsection (c) of this section, such card shall be effective for a period of
581 one year and shall include the name of the insured and insurer, the
582 policy number, the effective date of coverage, the year, make or model

583 and vehicle identification number of the insured vehicle and an
584 appropriate space wherein the insured may set forth the year, make or
585 model and vehicle identification number of any private passenger
586 motor vehicle that becomes covered as a result of a change in the
587 covered vehicle during the effective period of the identification card.
588 When an insured has five or more private passenger motor vehicles
589 registered in this state, the insurer may use the designation "all owned
590 vehicles" on each card in lieu of a specific vehicle description. Each
591 insurance company that delivers, issues for delivery or renews such
592 private passenger motor vehicle liability insurance in this state on or
593 after January 1, 2009, shall include on such card, the following notice,
594 printed in capital letters and boldface type:

595 NOTICE:

596 YOU HAVE THE RIGHT TO CHOOSE THE LICENSED REPAIR
597 SHOP WHERE THE DAMAGE TO YOUR MOTOR VEHICLE WILL
598 BE REPAIRED.

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

601 (a) No life insurance or annuity policy or contract shall be delivered
602 or issued for delivery to any person in this state, nor shall any
603 application, rider or endorsement be used in connection therewith,
604 until a copy of the form thereof shall have been filed with and
605 approved by the commissioner. The commissioner shall adopt
606 regulations in accordance with the provisions of chapter 54,
607 establishing a procedure for review of such policies. The commissioner
608 shall issue [an order] a decision disapproving the use of any such form
609 at any time if it does not comply with the requirements of law, or if it
610 contains a provision or provisions which are unfair or deceptive or
611 which encourage misrepresentation of the policy. The commissioner
612 shall specify the reason for his disapproval. The provisions of section
613 38a-19 shall apply to any such [order] decision issued by the
614 commissioner.

615 (b) The commissioner may prescribe requirements for disclosure
616 notices, illustrations or other explanatory materials said commissioner
617 deems necessary to protect policyholders.

618 [(b)] (c) Nothing in this chapter shall preclude the issuance of a life
619 insurance contract, including, but not limited to, a long-term care
620 policy as provided in section 38a-458, which includes an optional
621 health insurance rider, provided [,] the optional health insurance rider
622 [must be] is filed with and approved by the Insurance Commissioner
623 pursuant to section 38a-481, as amended by this act. Any company
624 offering such policies for sale in this state shall be licensed to sell
625 health insurance in this state pursuant to the provisions of section 38a-
626 41.

627 Sec. 12. Subsections (a) to (d), inclusive, of section 38a-481 of the
628 2010 supplement to the general statutes are repealed and the following
629 is substituted in lieu thereof (*Effective October 1, 2010*):

630 (a) (1) No individual health insurance policy shall be delivered or
631 issued for delivery to any person in this state, nor shall any
632 application, rider or endorsement be used in connection with such
633 policy, until a copy of the form thereof and of the classification of risks
634 and the premium rates have been filed with the commissioner. The
635 commissioner shall adopt regulations, in accordance with chapter 54,
636 to establish a procedure for reviewing such policies. The commissioner
637 shall disapprove the use of such form at any time if it does not comply
638 with the requirements of law, or if it contains a provision or provisions
639 [which] that are unfair or deceptive or [which] that encourage
640 misrepresentation of the policy. The commissioner shall notify, in
641 writing, the insurer [which] that has filed any such form of the
642 commissioner's disapproval, specifying the reasons for disapproval,
643 and [ordering] communicating that no such insurer shall deliver or
644 issue for delivery to any person in this state a policy on or containing
645 such form. The provisions of section 38a-19 shall apply to such [orders]
646 notifications of disapprovals.

647 (2) The commissioner may prescribe requirements for disclosure

648 notices, illustrations or other explanatory materials said commissioner
649 deems necessary to protect policyholders.

650 (b) No rate filed under the provisions of subsection (a) of this
651 section shall be effective until the expiration of thirty days after it has
652 been filed or unless sooner approved by the commissioner in
653 accordance with regulations adopted pursuant to this subsection. The
654 commissioner shall adopt regulations, in accordance with chapter 54,
655 to prescribe standards to [insure] ensure that such rates shall not be
656 excessive, inadequate or unfairly discriminatory. The commissioner
657 may disapprove such rate within thirty days after it has been filed if it
658 fails to comply with such standards, except that no rate filed under the
659 provisions of subsection (a) of this section for any Medicare
660 supplement policy shall be effective unless approved in accordance
661 with section 38a-474, as amended by this act.

662 (c) No insurance company, fraternal benefit society, hospital service
663 corporation, medical service corporation, health care center or other
664 entity which delivers or issues for delivery in this state any Medicare
665 supplement policies or certificates shall incorporate in its rates or
666 determinations to grant coverage for Medicare supplement insurance
667 policies or certificates any factors or values based on the age, gender,
668 previous claims history or the medical condition of any person covered
669 by such policy or certificate. [, except for plans "H" to "J", inclusive, as
670 provided in section 38a-495b. In plans "H" to "J", inclusive, previous
671 claims history and the medical condition of the applicant may be used
672 in determinations to grant coverage under Medicare supplement
673 policies and certificates issued prior to January 1, 2006.]

674 (d) Rates on a particular policy form [will] shall not be deemed
675 excessive if the insurer has filed a loss ratio guarantee with the
676 Insurance Commissioner [which] that meets the requirements of
677 subsection (e) of this section provided (1) the form of such loss ratio
678 guarantee has been explicitly approved by the Insurance
679 Commissioner, and (2) the current expected lifetime loss ratio is not
680 more than five per cent less than the filed lifetime loss ratio as certified

681 by an actuary. The insurer shall withdraw the policy form if the
682 commissioner determines that the lifetime loss ratio will not be met.
683 Rates also [will] shall not be deemed excessive if the insurer complies
684 with the terms of the loss ratio guarantee. The Insurance
685 Commissioner may adopt regulations, in accordance with chapter 54,
686 to [assure] ensure that the use of a loss ratio guarantee does not
687 constitute an unfair practice.

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

691 (b) In accordance with the regulations adopted pursuant to section
692 38a-495a, on and after July 1, 2005, there [are] shall be standardized
693 Medicare supplement insurance policies or certificates as designated
694 [as plans "A" to "L", inclusive] by the Centers for Medicare and
695 Medicaid Services.

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

698 (a) (1) No group health insurance policy, as defined by the
699 commissioner, or certificate shall be issued or delivered in this state
700 unless a copy of the form for such policy or certificate has been
701 submitted to and approved by the commissioner under the regulations
702 adopted pursuant to this section. The commissioner shall adopt
703 regulations, in accordance with chapter 54, concerning the provisions,
704 submission and approval of such policies and certificates and
705 establishing a procedure for reviewing such policies and certificates. [If
706 the commissioner issues an order disapproving the use of such form,
707 the] The commissioner shall disapprove the use of such form at any
708 time if it does not comply with the requirements of law, or if it
709 contains a provision or provisions that are unfair or deceptive or that
710 encourage misrepresentation of the policy. The commissioner shall
711 notify, in writing, the insurer that has filed any such form of the
712 commissioner's disapproval, specifying the reasons for disapproval,
713 and communicating that no such insurer shall deliver or issue for

714 delivery to any person in this state a policy on or containing such form.
715 The provisions of section 38a-19 shall apply to such [order]
716 notifications of disapprovals.

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

720 (b) No insurance company, fraternal benefit society, hospital service
721 corporation, medical service corporation, health care center or other
722 entity [which] that delivers or issues for delivery in this state any
723 Medicare supplement policies or certificates shall incorporate in its
724 rates or determinations to grant coverage for Medicare supplement
725 insurance policies or certificates any factors or values based on the age,
726 gender, previous claims history or the medical condition of any person
727 covered by such policy or certificate. [, except for plans "H" to "J",
728 inclusive, as provided in section 38a-495b. In plans "H" to "J", inclusive,
729 previous claims history and the medical condition of the applicant may
730 be used in determinations to grant coverage under Medicare
731 supplement policies and certificates issued prior to January 1, 2006.]

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

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

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

746 (15) (A) Failure by an insurer, or any other entity responsible for
747 providing payment to a health care provider pursuant to an insurance
748 policy, to pay accident and health claims, including, but not limited to,
749 claims for payment or reimbursement to health care providers, within
750 the time periods set forth in subparagraph (B) of this subdivision,
751 unless the Insurance Commissioner determines that a legitimate
752 dispute exists as to coverage, liability or damages or that the claimant
753 has fraudulently caused or contributed to the loss. Any insurer, or any
754 other entity responsible for providing payment to a health care
755 provider pursuant to an insurance policy, who fails to pay such a claim
756 or request within the time periods set forth in subparagraph (B) of this
757 subdivision shall pay the claimant or health care provider the amount
758 of such claim plus interest at the rate of fifteen per cent per annum, in
759 addition to any other penalties which may be imposed pursuant to
760 sections 38a-11, as amended by this act, 38a-25, 38a-41 to 38a-53,
761 inclusive, 38a-57 to 38a-60, inclusive, 38a-62 to 38a-64, inclusive, 38a-
762 76, 38a-83, 38a-84, 38a-117 to 38a-124, inclusive, 38a-129 to 38a-140,
763 inclusive, 38a-146 to 38a-155, inclusive, 38a-283, 38a-288 to 38a-290,
764 inclusive, 38a-319, 38a-320, 38a-459, 38a-464, 38a-815 to 38a-819,
765 inclusive, 38a-824 to 38a-826, inclusive, and 38a-828 to 38a-830,
766 inclusive. Whenever the interest due a claimant or health care provider
767 pursuant to this section is less than one dollar, the insurer shall deposit
768 such amount in a separate interest-bearing account in which all such
769 amounts shall be deposited. At the end of each calendar year each such
770 insurer shall donate such amount to The University of Connecticut
771 Health Center.

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

781 alleged deficiencies in information needed for processing a claim not
782 later than thirty days after the insurer receives a claim for payment or
783 reimbursement under the contract, and (ii) pay claims for payment or
784 reimbursement under the contract not later than thirty days after the
785 insurer receives the information requested.

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

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

794 (a) Any enrollee, or any provider acting on behalf of an enrollee
795 with the enrollee's consent, who has exhausted the internal
796 mechanisms provided by a managed care organization, health insurer
797 or utilization review company to appeal the denial of a claim based on
798 medical necessity or a determination not to certify an admission,
799 service, procedure or extension of stay, regardless of whether such
800 determination was made before, during or after the admission, service,
801 procedure or extension of stay, may appeal such denial or
802 determination to the commissioner. As used in this section and section
803 38a-478m, "health insurer" means any entity, other than a managed
804 care organization that delivers, issues for delivery, renews, amends or
805 continues an individual or group health insurance plan in this state
806 providing coverage of the type specified in subdivision (1), (2), (4),
807 (10), (11), (12), [and] (13) and (16) of section 38a-469, and "enrollee"
808 means a person who has contracted for or who participates in coverage
809 under an individual or group health insurance plan or a managed care
810 plan for such person or such person's eligible dependents.

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

813 The commissioner shall carry out a review as set forth in section 1 of
814 [this act] public act 09-179 of statutorily mandated health benefits
815 existing on or effective on July 1, 2009. The commissioner shall submit,
816 in accordance with section 11-4a of the general statutes, the findings to
817 the joint standing committee of the General Assembly having
818 cognizance of matters relating to insurance not later than January 1,
819 [2010] 2011.

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

823 (b) No insurance company, fraternal benefit society, hospital service
824 corporation, medical service corporation, health care center or other
825 entity which delivers or issues for delivery in this state any Medicare
826 supplement policies or certificates shall incorporate in its rates or
827 determinations to grant coverage for Medicare supplement insurance
828 policies or certificates any factors or values based on the age, gender,
829 previous claims history or the medical condition of any person covered
830 by such policy or certificate. [, except for plans "H" to "J", inclusive, as
831 provided in section 38a-495b. In plans "H" to "J", inclusive, previous
832 claims history and the medical condition of the applicant may be used
833 in determinations to grant coverage under Medicare supplement
834 policies and certificates issued prior to January 1, 2006.]

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

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

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

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

853 (a) Each insurance company, fraternal benefit society, hospital
854 service corporation, medical service corporation, health care center or
855 other entity in this state, on or after January 1, 1994, which delivers,
856 issues for delivery, continues or renews any Medicare supplement
857 insurance policies or certificates shall base the premium rates charged
858 on a community rate. Such rate shall not be based on age, gender,
859 previous claims history or the medical condition of the person covered
860 by such policy or certificate. Except as provided in subsection (c) of
861 this section, coverage shall not be denied on the basis of age, gender,
862 previous claim history or the medical condition of the person covered
863 by such policy or certificate. [, except for plans "H" to "J", inclusive, as
864 provided in section 38a-495b. In plans "H" to "J", inclusive, previous
865 claims history and the medical condition of the applicant may be used
866 in determinations to grant coverage under Medicare supplement
867 policies and certificates issued prior to January 1, 2006.]

868 (b) Nothing in this section shall prohibit an insurance company,
869 fraternal benefit society, hospital service corporation, medical service
870 corporation, health care center or other entity in this state issuing
871 Medicare supplement insurance policies or certificates from using its
872 usual and customary underwriting procedures, provided no such
873 company, society, corporation, center or other entity shall issue a
874 Medicare supplement policy or certificate based on the age, gender,
875 previous claims history or the medical condition of the applicant. [,
876 except that the previous claims history and the medical condition of
877 the applicant may be used in determinations to grant coverage under
878 Medicare supplement policies and certificates issued prior to January

879 1, 2006, for plans "H" to "J", inclusive.]

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

883 (k) (1) A person receiving benefits under sections 38a-858 to 38a-875,
884 inclusive, whether the benefits are payments of or on account of
885 contractual obligations, continuation of coverage or provision of
886 substitute or alternative coverages, shall be deemed to have assigned
887 (A) the rights under the covered policy or contract to the association to
888 the extent of the benefits received under sections 38a-858 to 38a-875,
889 inclusive, and (B) any [causes] cause of action against any person for
890 losses arising under, resulting from or otherwise relating to, the
891 covered policy or contract to the association to the extent of the
892 benefits received because of sections 38a-858 to 38a-875, inclusive. The
893 association may require an assignment to it of such rights or cause of
894 action by any payee, policy or contract owner, beneficiary, insured or
895 annuitant as a condition precedent to the receipt of any right or
896 benefits under sections 38a-858 to 38a-875, inclusive, upon the person.
897 The provisions of sections 52-225g to 52-225l, inclusive, shall not apply
898 to such rights or cause of action assigned to the association pursuant to
899 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)

JUD *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:

Agency Affected	Fund-Effect	FY 11 \$	FY 12 \$
Insurance Dept.	IF - Cost	875,000	875,000
Insurance Dept.	GF - Revenue Gain	6,510	10,690

Note: IF=Insurance Fund; GF=General Fund

Municipal Impact: None

Explanation

The bill eliminates a provision under current law that allows the Department of Insurance (DOI) to charge non-domestic insurance companies for market conduct examinations, resulting in a cost to DOI of \$875,000 in FY 11 and FY 12¹.

The bill also results in a General Fund revenue gain of \$6,510 in FY 11 and \$10,690 in FY 12. This revenue gain is generated from the following fees: 1) filing fees for arbitration of automobile disputes², resulting in a net General Fund revenue gain of \$1,510 in FY 11 and \$3,190 in FY 12³; and 2) a \$2,500 filing fee for acquisition of control of a domestic insurance company, established under the bill, resulting in a

¹ An average of 5 non-domestic insurance company market conduct examinations are performed annually by DOI consultants; the average cost per examination is \$175,000.

² The filing fee for arbitration of automobile disputes is \$20 for both insurers and claimants. This is changed under the bill to \$100 for insurers and \$50 for claimants.

³ 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.

net General Fund revenue gain of \$5,000 in FY 11 and \$7,500 in FY 12⁴.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to the number of: 1) non-domestic insurance company market conduct examinations; 2) automobile arbitration filings and; 3) filings for acquisition of control of a domestic insurance company.

⁴ This assumes an average of 3 acquisition of control of a domestic insurance company filings. 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.

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

-
- with the examination (§ 4);
7. revises the market conduct examination law with respect to costs 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. applies the external appeal statute to single service ancillary health coverage plans, including dental, vision, and prescription drug plans (§ 16);
 13. delays, from January 1, 2010 to January 1, 2011, the deadline for the insurance commissioner's report to the Insurance and Real Estate Committee on the mandated health insurance benefits 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 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

Under current law, the company being examined must pay examination costs. The bill removes this requirement with respect to out-of-state companies.

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 Connecticut. 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 to the Insurance Department toward the department's operating expenses.

It is unclear who pays the cost of examination when an out-of-state company is examined.

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, (File 207), 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.

Legislative History

The House referred the bill (File 288) to the Judiciary Committee, which reported out a substitute bill. The substitute deleted language regarding market conduct examinations. The deleted language (1) permitted the insurance commissioner to hire consultants to assist with examinations at the insurer’s expense and (2) granted immunity to

examiners performing their work in good faith.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 19 Nay 0 (03/18/2010)

Judiciary Committee

Joint Favorable Substitute

Yea 39 Nay 0 (04/20/2010)