



Substitute Senate Bill No. 849

Public Act No. 11-19

AN ACT CONCERNING THE LEGISLATIVE COMMISSIONERS' RECOMMENDATIONS FOR TECHNICAL REVISIONS AND MINOR CHANGES TO THE INSURANCE AND RELATED STATUTES.

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

Section 1. Subsection (d) of section 20-529a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(d) No appraisal management company shall prohibit or attempt to prohibit an appraiser from including or referencing in an appraisal report the appraisal fee, the name of the appraisal management company or the [client] client's or lender's name or identity.

Sec. 2. Subsection (a) of section 38a-155 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(a) Any consolidated hospital service corporation and medical service corporation organized and formed pursuant to sections 38a-199 to 38a-209, inclusive, or sections 38a-214 to 38a-225, inclusive, in existence on July 1, 1982, and possessing contingency reserves in an amount of fifty million dollars or more may, at its option and without reincorporation, convert to a domestic mutual insurance company

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under the laws of this state (1) by amending and restating its certificate of incorporation to grant it such powers consistent with the provisions of this section, provided the amended and restated certificate of incorporation shall not state that said domestic mutual insurance company is a nonprofit corporation or that it is created under the Nonstock Corporation Act, and (2) by obtaining a license pursuant to [sections] section 38a-41 to operate as a domestic mutual insurance company.

Sec. 3. Subsection (e) of section 38a-155 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(e) No consolidated hospital service corporation and medical service corporation [which] that converts to a domestic mutual insurance company under this section shall thereafter [be able to] avail itself of the provisions of either sections 38a-199 to 38a-209, inclusive, or sections 38a-214 to 38a-225, inclusive. Such company shall not organize or participate in the organization of, revert or convert to the status of, own or organize a subsidiary [which] that is, have common management or directors with, or in any other way be affiliated with, a corporation or other legal entity organized, formed or acting pursuant to said sections. Until the filing with the Secretary of the State of the amended and restated certificate of incorporation as provided herein, the permission currently granted to any such corporation by the Insurance Commissioner shall continue in full force and effect, and such corporation shall continue to provide comprehensive health care and related services to its present or future subscribers and covered persons by health care contracts and may make provision for the payment for such health care services. Upon converting to a domestic mutual insurance company, the company shall be subject to all of the laws of the state governing domestic mutual insurance companies and, except as otherwise provided in this section, shall have all of the

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powers of any other domestic mutual insurance company now or hereafter chartered or incorporated by this state and empowered to do an insurance business including, but not limited to, the power to establish, maintain, own and operate health care centers as a line of business.

Sec. 4. Subsection (d) of section 38a-335 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(d) With respect to the insured motor vehicle, the coverage afforded under the bodily injury liability and property damage liability provisions in any such policy shall apply to the named insured and relatives residing in [his] such insured's household unless any such [person] relative is specifically excluded by endorsement.

Sec. 5. Section 38a-430 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(a) No life insurance or annuity policy or contract shall be delivered or issued for delivery to any person in this state, nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof shall have been filed with and approved by the commissioner. The commissioner shall adopt regulations₂ in accordance with the provisions of chapter 54, establishing a procedure for review of such policies. The commissioner shall issue an order disapproving the use of any such form at any time if it does not comply with the requirements of law, or if it contains a provision or provisions [which] that are unfair or deceptive or [which] that encourage misrepresentation of the policy. The commissioner shall specify the reason for [his] the commissioner's disapproval. The provisions of section 38a-19 shall apply to any such order issued by the commissioner.

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

Sec. 6. Subdivision (1) of subsection (e) of section 38a-457 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(1) The face of every accelerated benefits policy shall contain: (A) A description of coverage which uses the terminology "accelerated", and (B) the following statement: "Benefits as specified under this policy will be reduced upon receipt of an accelerated benefit."

Sec. 7. Section 38a-472c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

For any policy delivered, issued for delivery, renewed, amended or continued in this state [on or after October 1, 2004,] that provides coverage for inpatient or outpatient dental services only, the person who issues the policy shall provide the insured or a licensed dentist acting on behalf of the insured, upon request, an estimate of reimbursement under the policy with respect to specific dental procedure codes ordered or recommended for the insured by a licensed dentist, except that the actual reimbursement may be adjusted based on factors such as the insured's eligibility, plan design, utilization of benefits and the actual claim submitted.

Sec. 8. Subsection (a) of section 38a-503d of the general statutes is

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repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state [on or after July 1, 1997,] shall provide coverage for at least forty-eight hours of inpatient care following a mastectomy or lymph node dissection, and shall provide coverage for a longer period of inpatient care if such care is recommended by the patient's treating physician after conferring with the patient. No such insurance policy may require mastectomy surgery or lymph node dissection to be performed on an outpatient basis. Outpatient surgery or shorter inpatient care is allowable under this section if the patient's treating physician recommends such outpatient surgery or shorter inpatient care after conferring with the patient.

Sec. 9. Subsection (a) of section 38a-530d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state [on or after July 1, 1997,] shall provide coverage for at least forty-eight hours of inpatient care following a mastectomy or lymph node dissection, and shall provide coverage for a longer period of inpatient care if such care is recommended by the patient's treating physician after conferring with the patient. No such insurance policy may require mastectomy surgery or lymph node dissection to be performed on an outpatient basis. Outpatient surgery or shorter inpatient care is allowable under this section if the patient's treating physician recommends such outpatient surgery or shorter inpatient care after conferring with the patient.

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Sec. 10. Subsection (d) of section 38a-504 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(d) (1) Each policy of the type specified in subsection (a) of this section that provides coverage for intravenously administered and orally administered anticancer medications used to kill or slow the growth of cancerous cells [] that are prescribed by a prescribing practitioner, as defined in section 20-571, shall provide coverage for orally administered anticancer medications on a basis that is no less favorable than intravenously administered anticancer medications.

(2) No insurance company, hospital service corporation, medical service corporation, health care center or fraternal benefit society that delivers, issues for delivery, renews, amends or continues in this state a policy of the type specified in subsection (a) of this section [] shall reclassify such anticancer medications or increase the coinsurance, copayment, deductible or other out-of-pocket expense imposed under such policy for such medications [] to achieve compliance with this subsection.

Sec. 11. Subsection (d) of section 38a-542 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(d) (1) Each policy of the type specified in subsection (a) of this section that provides coverage for intravenously administered and orally administered anticancer medications used to kill or slow the growth of cancerous cells [] that are prescribed by a prescribing practitioner, as defined in section 20-571, shall provide coverage for orally administered anticancer medications on a basis that is no less favorable than intravenously administered anticancer medications.

(2) No insurance company, hospital service corporation, medical

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service corporation, health care center or fraternal benefit society that delivers, issues for delivery, renews, amends or continues in this state a policy of the type specified in subsection (a) of this section [,] shall reclassify such anticancer medications or increase the coinsurance, copayment, deductible or other out-of-pocket expense imposed under such policy for such medications [,] to achieve compliance with this subsection.

Sec. 12. Subsections (a) and (b) of section 38a-519 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(a) No group health insurance policy that provides disability income protection coverage, delivered, issued for delivery, renewed, amended or continued in this state, and no application, rider or endorsement used in connection therewith shall contain an offset proviso. For the purposes of this subsection, [an] "offset proviso" means any provision of an insurance policy that allows the insurer to reduce its liability for loss or expense from sickness or from bodily injury of the insured by reason of any cost of living increase in other disability benefits that occur after the date a claim commences under such policy.

(b) For each group long-term disability income protection coverage policy delivered, issued for delivery, renewed, amended or continued in this state [,] that contains an offset, the insurer shall disclose to a policyholder in a separate document and in a conspicuous manner in not less than fourteen-point bold face type: (1) That the policy contains an offset; (2) that such offset will function to limit payments to an insured under the policy, taking into account Social Security disability benefits and other benefits the insured may receive; (3) for what other categories of benefits the policy will offset; (4) the [per cent] percentage of income the policy covers and the maximum dollar limit of the policy, if applicable; and (5) at least one example showing how such offset will operate. Such disclosure shall include a statement that, if an

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eligible individual wants a policy that does not contain an offset, the individual may contact an insurance agent or company for an individual policy.

Sec. 13. Subsection (a) of section 38a-546 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

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

Sec. 14. Section 38a-564 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

As used in this section [,] and sections 12-201, 12-211, 12-212a and 38a-565 to 38a-572, inclusive, as amended by this act:

(1) "Pool" means the Connecticut Small Employer Health Reinsurance Pool, established under section 38a-569.

(2) "Board" means the board of directors of the pool.

(3) "Eligible employee" means an employee who works a normal work week of twenty or more hours and includes a sole proprietor, a partner of a partnership or an independent contractor, provided such sole proprietor, partner or contractor is included as an employee under a health care plan of a small employer but does not include an employee who works on a seasonal, temporary or substitute basis. "Eligible employee" shall include any employee who is not actively at

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work but is covered under the small employer's health insurance plan pursuant to (A) workers' compensation, (B) continuation of benefits pursuant to section 38a-554, or (C) other applicable laws.

(4) (A) "Small employer" means any person, firm, corporation, limited liability company, partnership or association actively engaged in business or self-employed for at least three consecutive months who, on at least fifty per cent of its working days during the preceding twelve months, employed no more than fifty eligible employees, the majority of whom were employed within the state of Connecticut. "Small employer" includes a self-employed individual. For the purposes of determining the number of eligible employees under this subdivision: (i) Companies that are affiliated companies, as defined in section 33-840, or that are eligible to file a combined tax return for purposes of taxation under chapter 208 shall be considered one employer; (ii) employees covered through the employer by health insurance plans or insurance arrangements issued to or in accordance with a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act shall not be counted; (iii) employees who are not actively at work but are covered under the small employer's health insurance plan pursuant to workers' compensation, continuation of benefits pursuant to section 38a-554 or other applicable laws shall not be counted; and (iv) employees who work a normal work week of less than thirty hours shall not be counted. Except as otherwise specifically provided, provisions of this section and sections 12-201, 12-211, 12-212a [~~, this section~~] and [~~sections~~] 38a-565 to 38a-572, inclusive, as amended by this act, that apply to a small employer shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this definition.

(B) "Small employer" does not include (i) a municipality procuring health insurance pursuant to section 5-259, (ii) a private school in this

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state procuring health insurance through a health insurance plan or an insurance arrangement sponsored by an association of such private schools, (iii) a nonprofit organization procuring health insurance pursuant to section 5-259, unless the Secretary of the Office of Policy and Management and the State Comptroller make a request in writing to the Insurance Commissioner that such nonprofit organization be deemed a small employer for the purposes of this chapter, (iv) an association for personal care assistants procuring health insurance pursuant to section 5-259, or (v) a community action agency procuring health insurance pursuant to section 5-259.

(5) "Insurer" means any insurance company, hospital or medical service corporation, or health care center, authorized to transact health insurance business in this state.

(6) "Insurance arrangement" means any "multiple employer welfare arrangement", as defined in Section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time, except for any such arrangement that is fully insured within the meaning of Section 514(b)(6) of said act, as amended from time to time.

(7) "Health insurance plan" means any hospital and medical expense incurred policy, hospital or medical service plan contract and health care center subscriber contract and does not include (A) accident only, credit, dental, vision, Medicare supplement, long-term care or disability insurance, hospital indemnity coverage, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payments insurance, or insurance under which beneficiaries are payable without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, or (B) policies of specified disease or limited benefit health insurance, provided that the carrier offering such policies files on or before March first of each year a certification with the commissioner that contains the following: (i) A

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statement from the carrier certifying that such policies are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance; (ii) a summary description of each such policy including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender or other factors, charged for such policies in the state; and (iii) in the case of a policy that is described in this subparagraph and that is offered for the first time in this state on or after October 1, 1993, the carrier files with the commissioner the information and statement required in this subparagraph at least thirty days prior to the date such policy is issued or delivered in this state.

(8) "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to section 38a-569.

(9) "Late enrollee" means an eligible employee or dependent who requests enrollment in a small employer's health insurance plan following the initial enrollment period provided under the terms of the first plan for which such employee or dependent was eligible through such small employer, provided an eligible employee or dependent shall not be considered a late enrollee if (A) the request for enrollment is made within thirty days after termination of coverage provided under another group health insurance plan and if the individual had not initially requested coverage under such plan solely because he was covered under another group health insurance plan and coverage under that plan has ceased due to termination of employment, death of a spouse, or divorce, or due to that plan's involuntary termination or cancellation by its carrier for reasons other than nonpayment of premium, or (B) the individual is employed by an employer who offers multiple health insurance plans and the individual elects a different health insurance plan during an open enrollment period, or (C) a court has ordered coverage be provided for a spouse or minor child under a

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covered employee's plan and request for enrollment is made within thirty days after issuance of such court order, or (D) if the request for enrollment is made within thirty days after the marriage of such employee or the birth or adoption of the first child by such employee after the later of the commencement of the employer's plan or the date the pool becomes operational, and satisfactory evidence of such marriage, birth or adoption is provided to the small employer carrier.

(10) "Department" means the Insurance Department.

(11) "Special health care plan" means a health insurance plan for previously uninsured small employers, established by the board in accordance with section 38a-565 or by the Health Reinsurance Association in accordance with section 38a-570.

(12) "Small employer health care plan" means a health insurance plan for small employers, established by the board in accordance with section 38a-568.

(13) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health insurance plan covering such employee. "Dependent" shall also include any dependent that is covered under the small employer's health insurance plan pursuant to workers' compensation, continuation of benefits pursuant to section 38a-554 or other applicable laws.

(14) "Commissioner" means the Insurance Commissioner.

(15) "Member" means each insurer and insurance arrangement participating in the pool.

(16) "Small employer carrier" means any insurer or insurance arrangement which offers or maintains group health insurance plans covering eligible employees of one or more small employers.

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(17) "Preexisting conditions provision" means a policy provision which excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage as to a condition which, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinary prudent person to seek diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to a condition which is pregnancy existing on the effective date of coverage.

(18) "Base premium rate" means, as to any health insurance plan or insurance arrangement covering one or more employees of a small employer, the lowest new business premium rate charged by the insurer or insurance arrangement for the same or similar coverage which is equivalent in value under a plan or arrangement covering any small employer with similar case characteristics, other than claim experience, as determined by such insurer or insurance arrangement, except that as to any small employer carrier or insurance arrangement not issuing new health insurance plans or insurance arrangements to a small employer, "base premium rate" means the lowest rate charged a small employer for the same or similar coverage which is equivalent in value, under a plan or arrangement covering any small employer with similar case characteristics, other than claim experience, as determined by such insurer or insurance arrangement.

(19) "Low-income eligible employee" means an eligible employee of a small employer whose annualized wages from such small employer determined as of the effective date of the special health care plan or as of any anniversary of such effective date as certified to the insurer or insurance arrangement or the Health Reinsurance Association, as the case may be, by such small employer is less than three hundred per cent of the federal poverty level applicable to such person.

(20) "Medicare" means the Health Insurance for the Aged Act, Title

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XVIII of the Social Security Amendments of 1965, as amended from time to time.

(21) "Health Reinsurance Association" means the entity established and maintained in accordance with the provisions of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive.

(22) "Reimbursement rate" means, as to individuals covered under special health care plans or an individual special health care plan, seventy-five per cent of the Medicare reimbursement rate for benefits normally reimbursable under Medicare. For services or supplies not reimbursed by Medicare, such reimbursement shall be seventy-five per cent of the amount which would be payable under Medicare, if Medicare was responsible for benefit payments under such plans for such services and supplies, as determined by the board and approved by the commissioner.

(23) "Individual special health care plan" means a health insurance plan for individuals, issued by the Health Reinsurance Association in accordance with section 38a-571 or issued by an insurer in accordance with section 38a-565.

(24) "Low-income individual" means an individual whose adjusted gross income (AGI) for the individual and spouse, from the most recent federal tax return filed prior to the date of application for the individual special health care plan or prior to any anniversary of the effective date of the plan, as certified by such individual, is less than three hundred per cent of the applicable federal poverty level.

(25) "Medicare reimbursement rate" means the amount which would be payable under Medicare for benefits normally reimbursed under Medicare.

(26) "Health care center" means health care center as defined in section 38a-175.

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(27) "Case characteristics" means demographic or other objective characteristics of a small employer, including age, sex, family composition, location, size of group, administrative cost savings resulting from the administration of an association group plan or a plan written pursuant to section 5-259 and industry classification, as determined by a small employer carrier, that are considered by the small employer carrier in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage since issue are not case characteristics for the purpose of sections 38a-564 to 38a-572, inclusive.

(28) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of subdivisions (4), (6), (7) and (9) of section 38a-567 and the regulations promulgated by the commissioner pursuant to section 38a-567, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

Sec. 15. Subdivision (18) of section 38a-567 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(18) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles. Each small employer carrier shall file with the commissioner annually, on or before March fifteenth, an actuarial certification certifying that the carrier is in compliance with this part and that the rating methods have been

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derived using recognized actuarial principles consistent with the provisions of sections 38a-564 to 38a-573, inclusive, as amended by this act. Such certification shall be in a form and manner and shall contain such information, as determined by the commissioner. A copy of the certification shall be retained by the small employer carrier at its [principle] principal place of business. Any information and documentation described in this subdivision but not subject to the filing requirement shall be made available to the commissioner upon his request. Except in cases of violations of sections 38a-564 to 38a-573, inclusive, as amended by this act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

Sec. 16. Subparagraph (D)(iii) of subdivision (6) of subsection (b) of section 38a-686 of the general statutes, as amended by section 2 of public act 10-7, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(iii) If the insurer grants an exception pursuant to subparagraph (D)(i) of this subdivision, the insurer shall (I) consider only credit information that is not affected by the extraordinary life circumstance, or (II) treat the applicant as if such applicant had neutral or better than neutral credit information, as defined by the insurer.

Sec. 17. Section 38a-839 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

There is created a nonprofit unincorporated legal entity to be known as the Connecticut Insurance Guaranty Association. All insurers defined as member insurers in [subdivision (8) of] section 38a-838 shall be members of said association as a condition of their authority to transact insurance in this state. Said association shall perform its

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functions under a plan of operation established and approved under section 38a-842 and shall exercise its powers through a board of directors established under section 38a-840. For the purposes of administration and assessment, said association shall be divided into three separate accounts: (1) The workers' compensation insurance account; (2) the automobile insurance account; and (3) an account for all other insurance to which sections 38a-836 to 38a-853, inclusive, as amended by this act, apply.

Sec. 18. Subsections (a) and (b) of section 38a-841 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(a) Said association shall: (1) Be obligated to the extent of the covered claims existing prior to the determination of insolvency and arising within thirty days after the determination of insolvency, or before the policy expiration date if less than thirty days after the determination, or before the insured replaces the policy or causes its cancellation, if he does so within thirty days of such determination, provided such obligation shall be limited as follows: (A) With respect to covered claims for unearned premiums, to one-half of the unearned premium on any policy, subject to a maximum of two thousand dollars per policy; (B) with respect to covered claims other than for unearned premiums, such obligation shall include only that amount of each such claim which is in excess of one hundred dollars and is less than three hundred thousand dollars for claims arising under policies of insurers determined to be insolvent prior to October 1, 2007, and four hundred thousand dollars for claims arising under policies of insurers determined to be insolvent on or after October 1, 2007, except that said association shall pay the full amount of any such claim arising out of a workers' compensation policy, provided in no event shall said association be obligated (i) to any claimant in an amount in excess of the obligation of the insolvent insurer under the policy form or

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coverage from which the claim arises, or (ii) for any claim filed with the association after the expiration of two years from the date of the declaration of insolvency unless such claim arose out of a workers' compensation policy and was timely filed in accordance with section 31-294c; (2) be deemed the insurer to the extent of its obligations on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent; (3) allocate claims paid and expenses incurred among the three accounts, created by section 38a-839, as amended by this act, separately, and assess member insurers separately (A) in respect of each such account for such amounts as shall be necessary to pay the obligations of said association under subdivision (1) of this subsection [(a) of this section] subsequent to an insolvency; (B) the expenses of handling covered claims subsequent to an insolvency; (C) the cost of examinations under section 38a-846; and (D) such other expenses as are authorized by sections 38a-836 to 38a-853, inclusive, as amended by this act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of such member insurer for the calendar year preceding the assessment on the kinds of insurance in such account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance in such account. Each member insurer shall be notified of its assessment not later than thirty days before it is due. No member insurer may be assessed in any year on any account an amount greater than two per cent of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in said account, provided if, at the time an assessment is levied on the "all other insurance" account, as defined in subdivision (3) of section 38a-839, as amended by this act, the board of directors finds that at least fifty per cent of the total net direct written premiums of a member insurer and all its affiliates, for the year on which such assessment is based, were from policies issued or delivered in Connecticut, on risks located in this state, such member insurer shall

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be assessed only on such member insurer's net direct written premium that is attributable to the kind of insurance that gives rise to each covered claim. If the maximum assessment, together with the other assets of said association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available may be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. Said association may defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance provided that during the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when such payment will not reduce capital or surplus below the minimum amounts required for a certificate of authority. Such payments shall be refunded to those insurers receiving greater assessments because of such deferment or, at the election of the insurer, be credited against future assessments. Each member insurer serving as a servicing facility may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by such member insurer if they are chargeable to the account in respect of which the assessment is made; (4) investigate claims brought against said association and adjust, compromise, settle, and pay covered claims to the extent of said association's obligations, and deny all other claims. The association shall pay claims in any order it deems reasonable [] including, but not limited to, payment in the order of receipt or by classification. It may review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which such settlements, releases and judgments may be properly contested; (5) notify such persons as the commissioner may direct under subdivision (1) of subsection (b) of

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section 38a-843; (6) handle claims through its employees or through one or more insurers or other persons designated by said association as servicing facilities, provided such designation of a servicing facility shall be subject to the approval of the commissioner, and may be declined by a member insurer; (7) reimburse each such servicing facility for obligations of said association paid by such facility and for expenses incurred by such facility while handling claims on behalf of said association and shall pay such other expenses of said association as are authorized by sections 38a-836 to 38a-853, inclusive, as amended by this act.

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

Sec. 19. Subsection (c) of section 38a-843 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

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

Sec. 20. Subdivision (2) of section 38a-175 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(2) "Carrier" means a health care center, insurer, hospital [and] service corporation, medical service corporation or other entity responsible for the payment of benefits or provision of services under a group contract.

Sec. 21. Section 38a-482a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(a) No insurer, health care center, hospital [and] service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, continuing or amending any individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 in this state [on or after January 1, 2008,] shall deliver or issue for delivery in this state any such policy unless such policy contains a definition of "medically necessary" or "medical necessity" as follows: "Medically necessary" or "medical necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a

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patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For the purposes of this subsection, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

(b) The provisions of subsection (a) of this section shall not apply to any insurer, health care center, hospital [and] service corporation, medical service corporation or other entity that has entered into any national settlement agreement until the expiration of any such agreement.

Sec. 22. Section 38a-513c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(a) No insurer, health care center, hospital [and] service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, continuing or amending any group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 in this state [on or after January 1, 2008,] shall deliver or issue for delivery in this state any such policy unless such policy contains a definition of "medically necessary" or "medical necessity" as follows: "Medically necessary" or "medical necessity" means health care services that a

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physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For the purposes of this subsection, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

(b) The provisions of subsection (a) of this section shall not apply to any insurer, health care center, hospital [and] service corporation, medical service corporation or other entity that has entered into any national settlement agreement until the expiration of any such agreement.

Sec. 23. Section 38a-483b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

Except as otherwise provided in this title, each insurer, health care center, hospital [and] service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing any individual health insurance policy in this state [,] providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 [,] shall complete any coverage determination with respect to such policy and notify the insured or the insured's health care provider of its decision not later than forty-five

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days after a request for such determination is received by the insurer, health care center, hospital [and] service corporation, medical service corporation or other entity. In the case of a denial of coverage, such entity shall notify the insured and the insured's health care provider of the reasons for such denial. If the reasons for such denial include that the requested service is not medically necessary or is not a covered benefit under such policy, the entity shall (1) notify the insured that such insured may contact the Office of the Healthcare Advocate if the insured believes the insured has been given erroneous information, and (2) provide to such insured the contact information for said office.

Sec. 24. Section 38a-513a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

Except as otherwise provided in this title, each insurer, health care center, hospital [and] service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing any group health insurance policy in this state [] providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 [] shall complete any coverage determination with respect to such policy and notify the insured or the insured's health care provider of its decision not later than forty-five days after a request for such determination is received by the insurer, health care center, hospital [and] service corporation, medical service corporation or other entity. In the case of a denial of coverage, such entity shall notify the insured and the insured's health care provider of the reasons for such denial. If the reasons for such denial include that the requested service is not medically necessary or is not a covered benefit under such policy, the entity shall (1) notify the insured that such insured may contact the Office of the Healthcare Advocate if the insured believes the insured has been given erroneous information, and (2) provide to such insured the contact information for said office.

Sec. 25. Section 38a-491b of the general statutes is repealed and the

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following is substituted in lieu thereof (*Effective October 1, 2011*):

No insurer, health care center, hospital [and] service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, continuing or amending any individual health insurance policy in this state [on or after July 1, 2000,] providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, and no dental services plan offering or administering dental services, may refuse to accept or make reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon by an insured, subscriber or enrollee, provided (1) the dentist or oral surgeon charges the insured, subscriber or enrollee no more for services than the dentist or surgeon charges uninsured patients for the same services, and (2) the dentist or oral surgeon allows the insurer, health care center, corporation or entity to review the records related to the insured, subscriber or enrollee during regular business hours. The insurer, health care center, corporation or entity shall give the dentist or oral surgeon at least forty-eight hours' notice prior to such review. As used in this section, "assignment of benefits" means the transfer of dental care coverage reimbursement benefits or other rights under an insurance policy, subscription contract or dental services plan by an insured, subscriber or enrollee to a dentist or oral surgeon.

Sec. 26. Section 38a-517b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

No insurer, health care center, hospital [and] service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, continuing or amending any group health insurance policy in this state [on or after July 1, 2000,] providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, and no dental services plan offering or administering dental services, may refuse to accept or make

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reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon by an insured, subscriber or enrollee, provided (1) the dentist or oral surgeon charges the insured, subscriber or enrollee no more for services than the dentist or surgeon charges uninsured patients for the same services, and (2) the dentist or oral surgeon allows the insurer, health care center, corporation or entity to review the records related to the insured, subscriber or enrollee during regular business hours. The insurer, health care center, corporation or entity shall give the dentist or oral surgeon at least forty-eight hours' notice prior to such review. As used in this section, "assignment of benefits" means the transfer of dental care coverage reimbursement benefits or other rights under an insurance policy, subscription contract or dental services plan by an insured, subscriber or enrollee to a dentist or oral surgeon.

Sec. 27. Subsection (b) of section 38a-473 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

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

Sec. 28. Subsection (b) of section 38a-474 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective*

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October 1, 2011):

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

Sec. 29. Subsection (c) of section 38a-481 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

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

Sec. 30. Subsection (b) of section 38a-495b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective*

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October 1, 2011):

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

Sec. 31. Subsections (a) and (b) of section 38a-495c of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

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

(b) Nothing in this section shall prohibit an insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity in this state issuing Medicare supplement insurance policies or certificates from using its usual and customary underwriting procedures, provided no such company, society, corporation, center or other entity shall issue a

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Medicare supplement policy or certificate based on the age, gender, previous claims history or the medical condition of the applicant. [except that the previous claims history and the medical condition of the applicant may be used in determinations to grant coverage under Medicare supplement policies and certificates issued prior to January 1, 2006, for plans "H" to "J", inclusive.]

Sec. 32. Subsection (b) of section 38a-513 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

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

Sec. 33. Subsection (a) of section 38a-489 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(a) [Every] Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469, delivered, [or] issued for delivery, renewed, amended or continued in this state more than one hundred twenty days after July 1, 1971, [which] that provides that coverage of a dependent child shall terminate upon attainment of the limiting age

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for dependent children specified in the policy shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child if at such date the child is and continues thereafter to be both (1) incapable of self-sustaining employment by reason of mental or physical handicap, as certified by the child's physician on a form provided by the insurer, hospital or medical service corporation or health care center, and (2) chiefly dependent upon the policyholder or subscriber for support and maintenance.

Sec. 34. Subsection (a) of section 38a-515 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 delivered, [or] issued for delivery, renewed, amended or continued in this state more than one hundred twenty days after July 1, 1971, [which] that provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child if at such date the child is and continues thereafter to be both (1) incapable of self-sustaining employment by reason of mental or physical handicap, as certified by the child's physician on a form provided by the insurer, hospital or medical service corporation, or health care center, and (2) chiefly dependent upon such employee or member for support and maintenance.

Sec. 35. Section 38a-490 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(a) [Every] Each individual health insurance policy delivered, issued

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for delivery, renewed, amended or continued in this state providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 for a family member of the insured or subscriber shall, as to such family members' coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

(b) Coverage for such newly born child shall consist of coverage for injury and sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities within the limits of the policy.

(c) If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of such newly born child and payment of the required premium or fees shall be furnished to the insurer, hospital [or] service corporation, medical service corporation or health care center [within] not later than thirty-one days after the date of birth in order to continue coverage beyond such thirty-one-day period, provided failure to furnish such notice or pay such premium or fees shall not prejudice any claim originating within such thirty-one-day period.

[(d) The provisions of this section shall apply with respect to health insurance policies delivered or issued for delivery in this state on or after October 1, 1974, and to any health insurance policies which are thereafter amended to substantially alter or change benefits or coverages, and to any individual health insurance policies renewable at the option of such insurance company, hospital or medical service corporation or health care center which are thereafter renewed.]

Sec. 36. Section 38a-516 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

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(a) Each group health insurance policy delivered, issued for delivery, renewed, amended or continued in this state providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 for a family member of the insured or subscriber shall also provide as to such family members' coverage, that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

(b) Coverage for such newly born child shall consist of coverage for injury and sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities within the limits of the policy.

(c) If payment of a specific premium fee is required to provide coverage for a child, the policy may require that notification of birth of such newly born child and payment of the required premium or fees shall be furnished to the insurer, hospital [or] service corporation, medical service corporation or health care center [within] not later than thirty-one days after the date of birth in order to continue coverage beyond such thirty-one-day period, provided failure to furnish such notice or pay such premium shall not prejudice any claim originating within such thirty-one-day period.

[(d) The provisions of this section shall apply with respect to health insurance policies delivered or issued for delivery in this state on or after October 1, 1974, and to any health insurance policies which are thereafter amended to substantially alter or change benefits or coverages.]

Sec. 37. Section 38a-492a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

[Every] Each individual health insurance policy providing coverage

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of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469, delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after July 1, 1992,] shall provide coverage for hypodermic needles or syringes prescribed by a prescribing practitioner, as defined in subdivision (22) of section 20-571, for the purpose of administering medications for medical conditions, provided such medications are covered under the policy. Such benefits shall be subject to any policy provisions that apply to other services covered by such policy.

Sec. 38. Section 38a-518a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

[Every] Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469, delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after July 1, 1992,] shall provide coverage for hypodermic needles or syringes prescribed by a prescribing practitioner, as defined in subdivision (22) of section 20-571, for the purpose of administering medications for medical conditions, provided such medications are covered under the policy. Such benefits shall be subject to any policy provisions that apply to other services covered by such policy.

Sec. 39. Subsection (a) of section 38a-492b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(a) Each individual health insurance policy delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after October 1, 1994, which] that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for treatment of certain types of cancer shall not exclude coverage of any such drug on the basis that such drug has been prescribed for the treatment of a

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type of cancer for which the drug has not been approved by the federal Food and Drug Administration, provided the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia: (1) The U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional (USP DI); (2) The American Medical Association's Drug Evaluations (AMA DE); or (3) The American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHFS-DI).

Sec. 40. Subsection (a) of section 38a-518b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(a) Each group health insurance policy delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after October 1, 1994, which] that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for treatment of certain types of cancer shall not exclude coverage of any such drug on the basis that such drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration, provided the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia: (1) The U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional (USP DI); (2) The American Medical Association's Drug Evaluations (AMA DE); or (3) The American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHFS-DI).

Sec. 41. Subsection (a) of section 38a-493 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

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(a) [Every] Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after October 1, 1975,] shall provide coverage providing reimbursement for home health care to residents in this state.

Sec. 42. Subsection (a) of section 38a-520 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after October 1, 1975,] shall provide coverage providing reimbursement for home health care to residents in this state.

Sec. 43. Subsection (j) of section 38a-493 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(j) [Every] Each individual major medical expense policy delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after October 1, 1989,] shall provide coverage in accordance with the provisions of this section for home health care to residents in this state whose benefits are no longer provided under Medicare or any applicable individual health insurance policy.

Sec. 44. Subsection (j) of section 38a-520 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(j) Each major medical expense policy delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after October

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1, 1989,] shall provide coverage in accordance with the provisions of this section for home health care to residents in this state whose benefits are no longer provided under Medicare or any applicable individual or group health insurance policy.

Sec. 45. Subsection (b) of section 38a-496 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(b) [Every] Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after October 1, 1982, which] that provides coverage for expenses incurred for physical therapy shall provide coverage for occupational therapy provided in private practice or in a health care facility or in a partial hospitalization program on an exchange basis.

Sec. 46. Subsection (b) of section 38a-524 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(b) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after October 1, 1982, which] that provides coverage for expenses incurred for physical therapy shall provide coverage for occupational therapy provided in private practice or in a health care facility or in a partial hospitalization program on an exchange basis.

Sec. 47. Subsection (b) of section 38a-499 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

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(b) [Every] Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after October 1, 1984,] shall provide coverage for the services of physician assistants, certified nurse practitioners, certified psychiatric-mental health clinical nurse specialists and certified nurse-midwives if such services are within the individual's area of professional competence as established by education and licensure or certification and are currently reimbursed when rendered by any other licensed health care provider. Subject to the provisions of chapter 378 and sections 20-86a to 20-86e, inclusive, no insurer, hospital [or] service corporation, medical service corporation or health care center may require signature, referral or employment by any other health care provider as a condition of reimbursement, provided no insurer, hospital [or] service corporation, medical service corporation or health care center may be required to pay for duplicative services actually rendered by both a physician assistant or a certified registered nurse and any other health care provider. The payment of such benefits shall be subject to any policy provisions which apply to other licensed health practitioners providing the same services. Nothing in this section may be construed as permitting (1) any registered nurse to perform or provide services beyond the scope of practice permitted in chapter 378 and sections 20-86a to 20-86e, inclusive, or (2) any physician assistant to perform or provide services beyond the scope of practice permitted in chapter 370.

Sec. 48. Subsection (b) of section 38a-526 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(b) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 delivered, issued for delivery, [or] renewed, amended or

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continued in this state [on or after October 1, 1984,] shall provide coverage for the services of physician assistants, certified nurse practitioners, certified psychiatric-mental health clinical nurse specialists and certified nurse-midwives if such services are within the individual's area of professional competence as established by education and licensure or certification and are currently reimbursed when rendered by any other licensed health care provider. Subject to the provisions of chapter 378 and sections 20-86a to 20-86e, inclusive, no insurer, hospital [or] service corporation, medical service corporation or health care center may require signature, referral or employment by any other health care provider as a condition of reimbursement, provided no insurer, hospital [or] service corporation, medical service corporation or health care center may be required to pay for duplicative services actually rendered by both a physician assistant or a certified registered nurse and any other health care provider. The payment of such benefits shall be subject to any policy provisions which apply to other licensed health practitioners providing the same services. Nothing in this section may be construed as permitting (1) any registered nurse to perform or provide services beyond the scope of practice permitted in chapter 378 and sections 20-86a to 20-86e, inclusive, or (2) any physician assistant to perform or provide services beyond the scope of practice permitted in chapter 370.

Sec. 49. Subsection (a) of section 38a-503b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(a) As used in this section, "carrier" means each insurer, health care center, hospital [and] service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, [or] amending or continuing any individual health insurance policy in this state [on or after October 1, 1995,] providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section

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38a-469.

Sec. 50. Subsection (a) of section 38a-530b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(a) As used in this section, "carrier" means each insurer, health care center, hospital [and] service corporation, medical service corporation [,] or other entity delivering, issuing for delivery, renewing, [or] amending or continuing any group health insurance policy in this state [on or after October 1, 1995,] providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469.

Sec. 51. Subsection (a) of section 38a-503c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(a) As used in this section, "carrier" means each insurer, health care center, hospital [and] service corporation, medical service corporation [,] or other entity delivering, issuing for delivery, renewing, [or] amending or continuing any individual health insurance policy in this state [on or after October 1, 1996,] providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469.

Sec. 52. Subsection (a) of section 38a-530c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(a) As used in this section, "carrier" means each insurer, health care center, hospital [and] service corporation, medical service corporation [,] or other entity delivering, issuing for delivery, renewing, [or] amending or continuing any group health insurance policy in this state [on or after October 1, 1996,] providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469.

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Sec. 53. Subsection (a) of section 38a-503e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state [on or after October 1, 1999,] that provides coverage for outpatient prescription drugs approved by the federal Food and Drug Administration shall not exclude coverage for prescription contraceptive methods approved by the federal Food and Drug Administration.

Sec. 54. Subsection (a) of section 38a-530e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state [on or after October 1, 1999,] that provides coverage for outpatient prescription drugs approved by the federal Food and Drug Administration shall not exclude coverage for prescription contraceptive methods approved by the federal Food and Drug Administration.

Sec. 55. Section 38a-507 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

[Every] Each individual health insurance policy delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after October 1, 1989,] shall provide coverage for services rendered by a chiropractor licensed under chapter 372 to the same extent coverage is provided for services rendered by a physician, if such chiropractic

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services (1) treat a condition covered under such policy, and (2) are within those services a chiropractor is licensed to perform.

Sec. 56. Section 38a-534 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

[Every] Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6) and (11) of section 38a-469, delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after October 1, 1989,] shall provide coverage for services rendered by a chiropractor licensed under chapter 372 to the same extent coverage is provided for services rendered by a physician, if such chiropractic services (1) treat a condition covered under such policy, and (2) are within those services a chiropractor is licensed to perform.

Sec. 57. Section 38a-504a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after January 1, 2002,] shall provide coverage for the routine patient care costs, as defined in section 38a-504d, as amended by this act, associated with cancer clinical trials, in accordance with sections 38a-504b to 38a-504g, inclusive, as amended by this act. As used in this section and sections 38a-504b to 38a-504g, inclusive, as amended by this act, "cancer clinical trial" means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer in human beings. [, except that a clinical trial for the prevention of cancer is eligible for coverage only if it involves a therapeutic intervention and is a phase III clinical trial approved by one of the entities identified in section 38a-504b and

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is conducted at multiple institutions.]

Sec. 58. Section 38a-504b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

A clinical trial for the prevention of cancer shall be eligible for coverage only if it involves a therapeutic intervention, is a phase III clinical trial approved by one of the entities identified in this section, and is conducted at multiple institutions. In order to be eligible for coverage of routine patient care costs, as defined in section 38a-504d, as amended by this act, a cancer clinical trial shall be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by: (1) One of the National Institutes of Health; or (2) a National Cancer Institute affiliated cooperative group; or (3) the federal Food and Drug Administration as part of an investigational new drug or device exemption; or (4) the federal Department of Defense or Veterans Affairs. Nothing in sections 38a-504a to 38a-504g, inclusive, as amended by this act, shall be construed to require coverage for any single institution cancer clinical trial conducted solely under the approval of the institutional review board of an institution, or any trial that is no longer approved by an entity identified in subdivision (1), (2), (3) or (4) of this section.

Sec. 59. Section 38a-504c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

In order to be eligible for coverage of routine patient care costs, as defined in section 38a-504d, as amended by this act, the insurer, health care center or plan administrator may require that the person or entity seeking coverage for the cancer clinical trial provide: (1) Evidence satisfactory to the insurer, health care center or plan administrator that the insured person receiving coverage meets all of the patient selection criteria for the cancer clinical trial, including credible evidence in the form of clinical or preclinical data showing that the cancer clinical trial

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is likely to have a benefit for the insured person that is commensurate with the risks of participation in the cancer clinical trial to treat the person's condition; [and] (2) evidence that the appropriate informed consent has been received from the insured person; [and] (3) copies of any medical records, protocols, test results or other clinical information used by the physician or institution seeking to enroll the insured person in the cancer clinical trial; [and] (4) a summary of the anticipated routine patient care costs in excess of the costs for standard treatment; [and] (5) information from the physician or institution seeking to enroll the insured person in the clinical trial regarding those items, including any routine patient care costs, that are eligible for reimbursement by an entity other than the insurer or health care center, including the entity sponsoring the clinical trial; and (6) any additional information that may be reasonably required for the review of a request for coverage of the cancer clinical trial. The health plan or insurer shall request any additional information about a cancer clinical trial [within] not later than five business days [of] after receiving a request for coverage from an insured person or a physician seeking to enroll an insured person in a cancer clinical trial. Nothing in sections 38a-504a to 38a-504g, inclusive, as amended by this act, shall be construed to require the insurer or health care center to provide coverage for routine patient care costs that are eligible for reimbursement by an entity other than the insurer, including the entity sponsoring the cancer clinical trial.

Sec. 60. Subsection (a) of section 38a-504d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(a) For purposes of sections 38a-504a to 38a-504g, inclusive, as amended by this act, "routine patient care costs" means: (1) [Coverage for medically] Medically necessary health care services that are incurred as a result of the treatment being provided to the insured

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person for purposes of the cancer clinical trial that would otherwise be covered if such services were not rendered pursuant to a cancer clinical trial. Such services shall include those rendered by a physician, diagnostic or laboratory tests, hospitalization or other services provided to the [patient] insured person during the course of treatment in the cancer clinical trial for a condition, or one of its complications, that is consistent with the usual and customary standard of care and would be covered if the insured person were not enrolled in a cancer clinical trial. Such hospitalization shall include treatment at an out-of-network facility if such treatment is not available in-network and not eligible for reimbursement by the sponsors of such clinical trial; and (2) [coverage for routine patient care] costs incurred for drugs provided to the insured person, in accordance with section [38a-518b] 38a-492b, as amended by this act, provided such drugs have been approved for sale by the federal Food and Drug Administration.

Sec. 61. Subsection (b) of section 38a-504f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(b) Any insurer or health care center that receives the department form from a provider, hospital or institution seeking coverage for the routine patient care costs of an insured person in a cancer clinical trial shall approve or deny coverage for such services [within] not later than five business days [of] after receiving such request and any other reasonable supporting materials requested by the insurer or health plan pursuant to section 38a-504c, as amended by this act, except that an insurer or health care center that utilizes independent experts to review such requests shall respond [within] not later than ten business days after receiving such request and supporting materials. Requests for coverage of phase III clinical trials for the prevention of cancer pursuant to section [38a-504a] 38a-504b, as amended by this act, shall

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be approved or denied [within] not later than fourteen business days after receiving such request and supporting materials.

Sec. 62. Section 38a-542a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, [or] renewed, amended or continued in this state [on or after January 1, 2002,] shall provide coverage for the routine patient care costs, as defined in section 38a-542d, as amended by this act, associated with cancer clinical trials, in accordance with sections 38a-542b to 38a-542g, inclusive, as amended by this act. As used in this section and sections 38a-542b to 38a-542g, inclusive, as amended by this act, "cancer clinical trial" means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer in human beings. [, except that a clinical trial for the prevention of cancer is eligible for coverage only if it involves a therapeutic intervention and is a phase III clinical trial approved by one of the entities identified in section 38a-542b and is conducted at multiple institutions.]

Sec. 63. Section 38a-542b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

A clinical trial for the prevention of cancer shall be eligible for coverage only if it involves a therapeutic intervention, is a phase III clinical trial approved by one of the entities identified in this section, and is conducted at multiple institutions. In order to be eligible for coverage of routine patient care costs, as defined in section 38a-542d, as amended by this act, a cancer clinical trial shall be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by: (1) One of the National Institutes of

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Health; or (2) a National Cancer Institute affiliated cooperative group; or (3) the federal Food and Drug Administration as part of an investigational new drug or device exemption; or (4) the federal Department of Defense or Veterans Affairs. Nothing in sections 38a-542a to 38a-542g, inclusive, as amended by this act, shall be construed to require coverage for any single institution cancer clinical trial conducted solely under the approval of the institutional review board of an institution, or any trial that is no longer approved by an entity identified in subdivision (1), (2), (3) or (4) of this section.

Sec. 64. Section 38a-542c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

In order to be eligible for coverage of routine patient care costs, as defined in section 38a-542d, as amended by this act, the insurer, health care center or plan administrator may require that the person or entity seeking coverage for the cancer clinical trial provide: (1) Evidence satisfactory to the insurer, health care center or plan administrator that the insured person receiving coverage meets all of the patient selection criteria for the cancer clinical trial, including credible evidence in the form of clinical or pre-clinical data showing that the cancer clinical trial is likely to have a benefit for the insured person that is commensurate with the risks of participation in the cancer clinical trial to treat the person's condition; [and] (2) evidence that the appropriate informed consent has been received from the insured person; [and] (3) copies of any medical records, protocols, test results or other clinical information used by the physician or institution seeking to enroll the insured person in the cancer clinical trial; [and] (4) a summary of the anticipated routine patient care costs in excess of the costs for standard treatment; [and] (5) information from the physician or institution seeking to enroll the insured person in the clinical trial regarding those items, including any routine patient care costs, that are eligible for reimbursement by an entity other than the insurer or health care

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center, including the entity sponsoring the clinical trial; and (6) any additional information that may be reasonably required for the review of a request for coverage of the cancer clinical trial. The health plan or insurer shall request any additional information about a cancer clinical trial [within] not later than five business days [of] after receiving a request for coverage from an insured person or a physician seeking to enroll an insured person in a cancer clinical trial. Nothing in sections 38a-542a to 38a-542g, inclusive, as amended by this act, shall be construed to require the insurer or health care center to provide coverage for routine patient care costs that are eligible for reimbursement by an entity other than the insurer, including the entity sponsoring the cancer clinical trial.

Sec. 65. Subsection (a) of section 38a-542d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(a) For purposes of sections 38a-542a to 38a-542g, inclusive, as amended by this act, "routine patient care costs" means: (1) [Coverage for medically] Medically necessary health care services that are incurred as a result of the treatment being provided to the insured person for purposes of the cancer clinical trial that would otherwise be covered if such services were not rendered pursuant to a cancer clinical trial. Such services shall include those rendered by a physician, diagnostic or laboratory tests, hospitalization or other services provided to the [patient] insured person during the course of treatment in the cancer clinical trial for a condition, or one of its complications, that is consistent with the usual and customary standard of care and would be covered if the insured person were not enrolled in a cancer clinical trial. Such hospitalization shall include treatment at an out-of-network facility if such treatment is not available in-network and not eligible for reimbursement by the sponsors of such clinical trial; and (2) [coverage for routine patient

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care] costs incurred for drugs provided to the insured person, in accordance with section 38a-518b, as amended by this act, provided such drugs have been approved for sale by the federal Food and Drug Administration.

Sec. 66. Subsection (b) of section 38a-542f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(b) Any insurer or health care center that receives the department form from a provider, hospital or institution seeking coverage for the routine patient care costs of an insured person in a cancer clinical trial shall approve or deny coverage for such services [within] not later than five business days [of] after receiving such request and any other reasonable supporting materials requested by the insurer or health plan pursuant to section 38a-542c, as amended by this act, except that an insurer or health care center that utilizes independent experts to review such requests shall respond [within] not later than ten business days after receiving such request and supporting materials. Requests for coverage of phase III clinical trials for the prevention of cancer pursuant to section [38a-542a] 38a-542b, as amended by this act, shall be approved or denied [within] not later than fourteen business days after receiving such request and supporting materials.

Approved May 24, 2011