



Senate

General Assembly

File No. 13

January Session, 2011

Substitute Senate Bill No. 849

Senate, March 1, 2011

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

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

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

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2 repealed and the following is substituted in lieu thereof (*Effective*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

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

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9 repealed and the following is substituted in lieu thereof (*Effective*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

11 (a) Any consolidated hospital service corporation and medical
12 service corporation organized and formed pursuant to sections 38a-199

13 to 38a-209, inclusive, or sections 38a-214 to 38a-225, inclusive, in
14 existence on July 1, 1982, and possessing contingency reserves in an
15 amount of fifty million dollars or more may, at its option and without
16 reincorporation, convert to a domestic mutual insurance company
17 under the laws of this state (1) by amending and restating its certificate
18 of incorporation to grant it such powers consistent with the provisions
19 of this section, provided the amended and restated certificate of
20 incorporation shall not state that said domestic mutual insurance
21 company is a nonprofit corporation or that it is created under the
22 Nonstock Corporation Act, and (2) by obtaining a license pursuant to
23 [sections] section 38a-41 to operate as a domestic mutual insurance
24 company.

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26 repealed and the following is substituted in lieu thereof (*Effective*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

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

47 except as otherwise provided in this section, shall have all of the
48 powers of any other domestic mutual insurance company now or
49 hereafter chartered or incorporated by this state and empowered to do
50 an insurance business including, but not limited to, the power to
51 establish, maintain, own and operate health care centers as a line of
52 business.

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

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

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

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

77 (b) Nothing in this chapter shall preclude the issuance of a life
78 insurance contract [,] including, but not limited to, a long-term care

79 policy as provided in section 38a-458, [which] that includes an optional
80 health insurance rider, provided [,] the optional health insurance rider
81 [must be] is filed with and approved by the Insurance Commissioner
82 pursuant to section 38a-481, as amended by this act. Any company
83 offering such policies for sale in this state shall be licensed to sell
84 health insurance in this state pursuant to the provisions of section 38a-
85 41.

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

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

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

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

105 Sec. 8. Subsection (a) of section 38a-503d of the general statutes is
106 repealed and the following is substituted in lieu thereof (*Effective*
107 *October 1, 2011*):

108 (a) Each individual health insurance policy providing coverage of
109 the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of

110 section 38a-469 delivered, issued for delivery, amended, renewed or
111 continued in this state [on or after July 1, 1997,] shall provide coverage
112 for at least forty-eight hours of inpatient care following a mastectomy
113 or lymph node dissection, and shall provide coverage for a longer
114 period of inpatient care if such care is recommended by the patient's
115 treating physician after conferring with the patient. No such insurance
116 policy may require mastectomy surgery or lymph node dissection to
117 be performed on an outpatient basis. Outpatient surgery or shorter
118 inpatient care is allowable under this section if the patient's treating
119 physician recommends such outpatient surgery or shorter inpatient
120 care after conferring with the patient.

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

124 (a) Each group health insurance policy providing coverage of the
125 type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section
126 38a-469 delivered, issued for delivery, amended, renewed or continued
127 in this state [on or after July 1, 1997,] shall provide coverage for at least
128 forty-eight hours of inpatient care following a mastectomy or lymph
129 node dissection, and shall provide coverage for a longer period of
130 inpatient care if such care is recommended by the patient's treating
131 physician after conferring with the patient. No such insurance policy
132 may require mastectomy surgery or lymph node dissection to be
133 performed on an outpatient basis. Outpatient surgery or shorter
134 inpatient care is allowable under this section if the patient's treating
135 physician recommends such outpatient surgery or shorter inpatient
136 care after conferring with the patient.

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

140 (d) (1) Each policy of the type specified in subsection (a) of this
141 section that provides coverage for intravenously administered and
142 orally administered anticancer medications used to kill or slow the

143 growth of cancerous cells [.] that are prescribed by a prescribing
144 practitioner, as defined in section 20-571, shall provide coverage for
145 orally administered anticancer medications on a basis that is no less
146 favorable than intravenously administered anticancer medications.

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

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

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

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

173 Sec. 12. Subsections (a) and (b) of section 38a-519 of the general
174 statutes are repealed and the following is substituted in lieu thereof

175 (Effective October 1, 2011):

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

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

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

203 (a) In order to assure reasonable continuation of coverage and
204 extension of benefits to the citizens of this state, each group health
205 insurance policy, regardless of the number of insureds, providing
206 coverage of the type specified in subdivisions (1), (2), (3), (4), (11) and
207 (12) of section 38a-469, delivered, issued for delivery, renewed,

208 amended or continued in this state shall, subject to the provisions of
209 subsection (d) of this section, contain those provisions described in
210 subsections (b) and (d) of section 38a-554.

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

213 As used in this section [] and sections 12-201, 12-211, 12-212a and
214 38a-565 to 38a-572, inclusive, as amended by this act:

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

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

218 (3) "Eligible employee" means an employee who works a normal
219 work week of twenty or more hours and includes a sole proprietor, a
220 partner of a partnership or an independent contractor, provided such
221 sole proprietor, partner or contractor is included as an employee under
222 a health care plan of a small employer but does not include an
223 employee who works on a seasonal, temporary or substitute basis.
224 "Eligible employee" shall include any employee who is not actively at
225 work but is covered under the small employer's health insurance plan
226 pursuant to (A) workers' compensation, (B) continuation of benefits
227 pursuant to section 38a-554, or (C) other applicable laws.

228 (4) (A) "Small employer" means any person, firm, corporation,
229 limited liability company, partnership or association actively engaged
230 in business or self-employed for at least three consecutive months
231 who, on at least fifty per cent of its working days during the preceding
232 twelve months, employed no more than fifty eligible employees, the
233 majority of whom were employed within the state of Connecticut.
234 "Small employer" includes a self-employed individual. For the
235 purposes of determining the number of eligible employees under this
236 subdivision: (i) Companies that are affiliated companies, as defined in
237 section 33-840, or that are eligible to file a combined tax return for
238 purposes of taxation under chapter 208 shall be considered one

239 employer; (ii) employees covered through the employer by health
240 insurance plans or insurance arrangements issued to or in accordance
241 with a trust established pursuant to collective bargaining subject to the
242 federal Labor Management Relations Act shall not be counted; (iii)
243 employees who are not actively at work but are covered under the
244 small employer's health insurance plan pursuant to workers'
245 compensation, continuation of benefits pursuant to section 38a-554 or
246 other applicable laws shall not be counted; and (iv) employees who
247 work a normal work week of less than thirty hours shall not be
248 counted. Except as otherwise specifically provided, provisions of this
249 section and sections 12-201, 12-211, 12-212a [, this section] and
250 [sections] 38a-565 to 38a-572, inclusive, as amended by this act, that
251 apply to a small employer shall continue to apply until the plan
252 anniversary following the date the employer no longer meets the
253 requirements of this definition.

254 (B) "Small employer" does not include (i) a municipality procuring
255 health insurance pursuant to section 5-259, (ii) a private school in this
256 state procuring health insurance through a health insurance plan or an
257 insurance arrangement sponsored by an association of such private
258 schools, (iii) a nonprofit organization procuring health insurance
259 pursuant to section 5-259, unless the Secretary of the Office of Policy
260 and Management and the State Comptroller make a request in writing
261 to the Insurance Commissioner that such nonprofit organization be
262 deemed a small employer for the purposes of this chapter, (iv) an
263 association for personal care assistants procuring health insurance
264 pursuant to section 5-259, or (v) a community action agency procuring
265 health insurance pursuant to section 5-259.

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

269 (6) "Insurance arrangement" means any "multiple employer welfare
270 arrangement", as defined in Section 3 of the Employee Retirement
271 Income Security Act of 1974 (ERISA), as amended from time to time,

272 except for any such arrangement that is fully insured within the
273 meaning of Section 514(b)(6) of said act, as amended from time to time.

274 (7) "Health insurance plan" means any hospital and medical expense
275 incurred policy, hospital or medical service plan contract and health
276 care center subscriber contract and does not include (A) accident only,
277 credit, dental, vision, Medicare supplement, long-term care or
278 disability insurance, hospital indemnity coverage, coverage issued as a
279 supplement to liability insurance, insurance arising out of a workers'
280 compensation or similar law, automobile medical-payments insurance,
281 or insurance under which beneficiaries are payable without regard to
282 fault and which is statutorily required to be contained in any liability
283 insurance policy or equivalent self-insurance, or (B) policies of
284 specified disease or limited benefit health insurance, provided that the
285 carrier offering such policies files on or before March first of each year
286 a certification with the commissioner that contains the following: (i) A
287 statement from the carrier certifying that such policies are being
288 offered and marketed as supplemental health insurance and not as a
289 substitute for hospital or medical expense insurance; (ii) a summary
290 description of each such policy including the average annual premium
291 rates, or range of premium rates in cases where premiums vary by age,
292 gender or other factors, charged for such policies in the state; and (iii)
293 in the case of a policy that is described in this subparagraph and that is
294 offered for the first time in this state on or after October 1, 1993, the
295 carrier files with the commissioner the information and statement
296 required in this subparagraph at least thirty days prior to the date such
297 policy is issued or delivered in this state.

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

301 (9) "Late enrollee" means an eligible employee or dependent who
302 requests enrollment in a small employer's health insurance plan
303 following the initial enrollment period provided under the terms of the
304 first plan for which such employee or dependent was eligible through

305 such small employer, provided an eligible employee or dependent
306 shall not be considered a late enrollee if (A) the request for enrollment
307 is made within thirty days after termination of coverage provided
308 under another group health insurance plan and if the individual had
309 not initially requested coverage under such plan solely because he was
310 covered under another group health insurance plan and coverage
311 under that plan has ceased due to termination of employment, death of
312 a spouse, or divorce, or due to that plan's involuntary termination or
313 cancellation by its carrier for reasons other than nonpayment of
314 premium, or (B) the individual is employed by an employer who offers
315 multiple health insurance plans and the individual elects a different
316 health insurance plan during an open enrollment period, or (C) a court
317 has ordered coverage be provided for a spouse or minor child under a
318 covered employee's plan and request for enrollment is made within
319 thirty days after issuance of such court order, or (D) if the request for
320 enrollment is made within thirty days after the marriage of such
321 employee or the birth or adoption of the first child by such employee
322 after the later of the commencement of the employer's plan or the date
323 the pool becomes operational, and satisfactory evidence of such
324 marriage, birth or adoption is provided to the small employer carrier.

325 (10) "Department" means the Insurance Department.

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

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

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

338 38a-554 or other applicable laws.

339 (14) "Commissioner" means the Insurance Commissioner.

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

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

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

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

368 (19) "Low-income eligible employee" means an eligible employee of

369 a small employer whose annualized wages from such small employer
370 determined as of the effective date of the special health care plan or as
371 of any anniversary of such effective date as certified to the insurer or
372 insurance arrangement or the Health Reinsurance Association, as the
373 case may be, by such small employer is less than three hundred per
374 cent of the federal poverty level applicable to such person.

375 (20) "Medicare" means the Health Insurance for the Aged Act, Title
376 XVIII of the Social Security Amendments of 1965, as amended from
377 time to time.

378 (21) "Health Reinsurance Association" means the entity established
379 and maintained in accordance with the provisions of sections 38a-505,
380 38a-546 and 38a-551 to 38a-559, inclusive.

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

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

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

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

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

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

415 (28) "Actuarial certification" means a written statement by a member
416 of the American Academy of Actuaries or other individual acceptable
417 to the commissioner that a small employer carrier is in compliance
418 with the provisions of subdivisions (4), (6), (7) and (9) of section 38a-
419 567 and the regulations promulgated by the commissioner pursuant to
420 section 38a-567, based upon the person's examination, including a
421 review of the appropriate records and of the actuarial assumptions and
422 methods used by the small employer carrier in establishing premium
423 rates for applicable health benefit plans.

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

427 (18) Each small employer carrier shall maintain at its principal place
428 of business a complete and detailed description of its rating practices
429 and renewal underwriting practices, including information and
430 documentation that demonstrates that its rating methods and practices
431 are based upon commonly accepted actuarial assumptions and are in

432 accordance with sound actuarial principles. Each small employer
433 carrier shall file with the commissioner annually, on or before March
434 fifteenth, an actuarial certification certifying that the carrier is in
435 compliance with this part and that the rating methods have been
436 derived using recognized actuarial principles consistent with the
437 provisions of sections 38a-564 to 38a-573, inclusive, as amended by this
438 act. Such certification shall be in a form and manner and shall contain
439 such information, as determined by the commissioner. A copy of the
440 certification shall be retained by the small employer carrier at its
441 [principle] principal place of business. Any information and
442 documentation described in this subdivision but not subject to the
443 filing requirement shall be made available to the commissioner upon
444 his request. Except in cases of violations of sections 38a-564 to 38a-573,
445 inclusive, as amended by this act, the information shall be considered
446 proprietary and trade secret information and shall not be subject to
447 disclosure by the commissioner to persons outside of the department
448 except as agreed to by the small employer carrier or as ordered by a
449 court of competent jurisdiction.

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

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

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

461 There is created a nonprofit unincorporated legal entity to be known
462 as the Connecticut Insurance Guaranty Association. All insurers
463 defined as member insurers in [subdivision (8) of] section 38a-838 shall
464 be members of said association as a condition of their authority to

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

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

477 (a) Said association shall: (1) Be obligated to the extent of the
478 covered claims existing prior to the determination of insolvency and
479 arising within thirty days after the determination of insolvency, or
480 before the policy expiration date if less than thirty days after the
481 determination, or before the insured replaces the policy or causes its
482 cancellation, if he does so within thirty days of such determination,
483 provided such obligation shall be limited as follows: (A) With respect
484 to covered claims for unearned premiums, to one-half of the unearned
485 premium on any policy, subject to a maximum of two thousand dollars
486 per policy; (B) with respect to covered claims other than for unearned
487 premiums, such obligation shall include only that amount of each such
488 claim which is in excess of one hundred dollars and is less than three
489 hundred thousand dollars for claims arising under policies of insurers
490 determined to be insolvent prior to October 1, 2007, and four hundred
491 thousand dollars for claims arising under policies of insurers
492 determined to be insolvent on or after October 1, 2007, except that said
493 association shall pay the full amount of any such claim arising out of a
494 workers' compensation policy, provided in no event shall said
495 association be obligated (i) to any claimant in an amount in excess of
496 the obligation of the insolvent insurer under the policy form or
497 coverage from which the claim arises, or (ii) for any claim filed with
498 the association after the expiration of two years from the date of the

499 declaration of insolvency unless such claim arose out of a workers'
500 compensation policy and was timely filed in accordance with section
501 31-294c; (2) be deemed the insurer to the extent of its obligations on the
502 covered claims and to such extent shall have all rights, duties, and
503 obligations of the insolvent insurer as if the insurer had not become
504 insolvent; (3) allocate claims paid and expenses incurred among the
505 three accounts, created by section 38a-839, as amended by this act,
506 separately, and assess member insurers separately (A) in respect of
507 each such account for such amounts as shall be necessary to pay the
508 obligations of said association under subdivision (1) of this subsection
509 [(a) of this section] subsequent to an insolvency; (B) the expenses of
510 handling covered claims subsequent to an insolvency; (C) the cost of
511 examinations under section 38a-846; and (D) such other expenses as
512 are authorized by sections 38a-836 to 38a-853, inclusive, as amended
513 by this act. The assessments of each member insurer shall be in the
514 proportion that the net direct written premiums of such member
515 insurer for the calendar year preceding the assessment on the kinds of
516 insurance in such account bears to the net direct written premiums of
517 all member insurers for the calendar year preceding the assessment on
518 the kinds of insurance in such account. Each member insurer shall be
519 notified of its assessment not later than thirty days before it is due. No
520 member insurer may be assessed in any year on any account an
521 amount greater than two per cent of that member insurer's net direct
522 written premiums for the calendar year preceding the assessment on
523 the kinds of insurance in said account, provided if, at the time an
524 assessment is levied on the "all other insurance" account, as defined in
525 subdivision (3) of section 38a-839, as amended by this act, the board of
526 directors finds that at least fifty per cent of the total net direct written
527 premiums of a member insurer and all its affiliates, for the year on
528 which such assessment is based, were from policies issued or delivered
529 in Connecticut, on risks located in this state, such member insurer shall
530 be assessed only on such member insurer's net direct written premium
531 that is attributable to the kind of insurance that gives rise to each
532 covered claim. If the maximum assessment, together with the other
533 assets of said association in any account, does not provide in any one

534 year in any account an amount sufficient to make all necessary
535 payments from that account, the funds available may be prorated and
536 the unpaid portion shall be paid as soon thereafter as funds become
537 available. Said association may defer, in whole or in part, the
538 assessment of any member insurer, if the assessment would cause the
539 member insurer's financial statement to reflect amounts of capital or
540 surplus less than the minimum amounts required for a certificate of
541 authority by any jurisdiction in which the member insurer is
542 authorized to transact insurance provided that during the period of
543 deferment, no dividends shall be paid to shareholders or
544 policyholders. Deferred assessments shall be paid when such payment
545 will not reduce capital or surplus below the minimum amounts
546 required for a certificate of authority. Such payments shall be refunded
547 to those insurers receiving greater assessments because of such
548 deferment or, at the election of the insurer, be credited against future
549 assessments. Each member insurer serving as a servicing facility may
550 set off against any assessment, authorized payments made on covered
551 claims and expenses incurred in the payment of such claims by such
552 member insurer if they are chargeable to the account in respect of
553 which the assessment is made; (4) investigate claims brought against
554 said association and adjust, compromise, settle, and pay covered
555 claims to the extent of said association's obligations, and deny all other
556 claims. The association shall pay claims in any order it deems
557 reasonable [] including, but not limited to, payment in the order of
558 receipt or by classification. It may review settlements, releases and
559 judgments to which the insolvent insurer or its insureds were parties
560 to determine the extent to which such settlements, releases and
561 judgments may be properly contested; (5) notify such persons as the
562 commissioner may direct under subdivision (1) of subsection (b) of
563 section 38a-843; (6) handle claims through its employees or through
564 one or more insurers or other persons designated by said association
565 as servicing facilities, provided such designation of a servicing facility
566 shall be subject to the approval of the commissioner, and may be
567 declined by a member insurer; (7) reimburse each such servicing
568 facility for obligations of said association paid by such facility and for

569 expenses incurred by such facility while handling claims on behalf of
570 said association and shall pay such other expenses of said association
571 as are authorized by sections 38a-836 to 38a-853, inclusive, as amended
572 by this act.

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

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

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

602 pendency of any such petitions to show cause shall act as a stay of
603 execution of any such order. Petitions under this section shall be
604 privileged in respect of trial assignment.

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

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

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

614 (a) No insurer, health care center, hospital [and] service corporation,
615 medical service corporation or other entity delivering, issuing for
616 delivery, renewing, continuing or amending any individual health
617 insurance policy providing coverage of the type specified in
618 subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 in this
619 state [on or after January 1, 2008,] shall deliver or issue for delivery in
620 this state any such policy unless such policy contains a definition of
621 "medically necessary" or "medical necessity" as follows: "Medically
622 necessary" or "medical necessity" means health care services that a
623 physician, exercising prudent clinical judgment, would provide to a
624 patient for the purpose of preventing, evaluating, diagnosing or
625 treating an illness, injury, disease or its symptoms, and that are: (1) In
626 accordance with generally accepted standards of medical practice; (2)
627 clinically appropriate, in terms of type, frequency, extent, site and
628 duration and considered effective for the patient's illness, injury or
629 disease; and (3) not primarily for the convenience of the patient,
630 physician or other health care provider and not more costly than an
631 alternative service or sequence of services at least as likely to produce
632 equivalent therapeutic or diagnostic results as to the diagnosis or
633 treatment of that patient's illness, injury or disease. For the purposes of
634 this subsection, "generally accepted standards of medical practice"

635 means standards that are based on credible scientific evidence
636 published in peer-reviewed medical literature generally recognized by
637 the relevant medical community or otherwise consistent with the
638 standards set forth in policy issues involving clinical judgment.

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

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

646 (a) No insurer, health care center, hospital [and] service corporation,
647 medical service corporation or other entity delivering, issuing for
648 delivery, renewing, continuing or amending any group health
649 insurance policy providing coverage of the type specified in
650 subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 in this
651 state [on or after January 1, 2008,] shall deliver or issue for delivery in
652 this state any such policy unless such policy contains a definition of
653 "medically necessary" or "medical necessity" as follows: "Medically
654 necessary" or "medical necessity" means health care services that a
655 physician, exercising prudent clinical judgment, would provide to a
656 patient for the purpose of preventing, evaluating, diagnosing or
657 treating an illness, injury, disease or its symptoms, and that are: (1) In
658 accordance with generally accepted standards of medical practice; (2)
659 clinically appropriate, in terms of type, frequency, extent, site and
660 duration and considered effective for the patient's illness, injury or
661 disease; and (3) not primarily for the convenience of the patient,
662 physician or other health care provider and not more costly than an
663 alternative service or sequence of services at least as likely to produce
664 equivalent therapeutic or diagnostic results as to the diagnosis or
665 treatment of that patient's illness, injury or disease. For the purposes of
666 this subsection, "generally accepted standards of medical practice"
667 means standards that are based on credible scientific evidence

668 published in peer-reviewed medical literature generally recognized by
669 the relevant medical community or otherwise consistent with the
670 standards set forth in policy issues involving clinical judgment.

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

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

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

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

698 Except as otherwise provided in this title, each insurer, health care
699 center, hospital [and] service corporation, medical service corporation

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

716 Sec. 25. Section 38a-491b of the general statutes is repealed and the
717 following is substituted in lieu thereof (*Effective October 1, 2011*):

718 No insurer, health care center, hospital [and] service corporation,
719 medical service corporation or other entity delivering, issuing for
720 delivery, renewing, continuing or amending any individual health
721 insurance policy in this state [on or after July 1, 2000,] providing
722 coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)
723 of section 38a-469, and no dental services plan offering or
724 administering dental services, may refuse to accept or make
725 reimbursement pursuant to an assignment of benefits made to a
726 dentist or oral surgeon by an insured, subscriber or enrollee, provided
727 (1) the dentist or oral surgeon charges the insured, subscriber or
728 enrollee no more for services than the dentist or surgeon charges
729 uninsured patients for the same services, and (2) the dentist or oral
730 surgeon allows the insurer, health care center, corporation or entity to
731 review the records related to the insured, subscriber or enrollee during
732 regular business hours. The insurer, health care center, corporation or
733 entity shall give the dentist or oral surgeon at least forty-eight hours'

734 notice prior to such review. As used in this section, "assignment of
735 benefits" means the transfer of dental care coverage reimbursement
736 benefits or other rights under an insurance policy, subscription
737 contract or dental services plan by an insured, subscriber or enrollee to
738 a dentist or oral surgeon.

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

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

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

765 (b) No insurance company, fraternal benefit society, hospital service
766 corporation, medical service corporation, health care center or other

767 entity which delivers or issues for delivery in this state any Medicare
768 supplement policies or certificates shall incorporate in its rates or
769 determinations to grant coverage for Medicare supplement insurance
770 policies or certificates any factors or values based on the age, gender,
771 previous claims history or the medical condition of any person covered
772 by such policy or certificate. [, except for plans "H" to "J", inclusive, as
773 provided in section 38a-495b. In plans "H" to "J", inclusive, previous
774 claims history and the medical condition of the applicant may be used
775 in determinations to grant coverage under Medicare supplement
776 policies and certificates issued prior to January 1, 2006.]

777 Sec. 28. Subsection (b) of section 38a-474 of the general statutes is
778 repealed and the following is substituted in lieu thereof (*Effective*
779 *October 1, 2011*):

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

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

795 (c) No insurance company, fraternal benefit society, hospital service
796 corporation, medical service corporation, health care center or other
797 entity which delivers or issues for delivery in this state any Medicare
798 supplement policies or certificates shall incorporate in its rates or
799 determinations to grant coverage for Medicare supplement insurance

800 policies or certificates any factors or values based on the age, gender,
801 previous claims history or the medical condition of any person covered
802 by such policy or certificate. [, except for plans "H" to "J", inclusive, as
803 provided in section 38a-495b. In plans "H" to "J", inclusive, previous
804 claims history and the medical condition of the applicant may be used
805 in determinations to grant coverage under Medicare supplement
806 policies and certificates issued prior to January 1, 2006.]

807 Sec. 30. Subsection (b) of section 38a-495b of the general statutes is
808 repealed and the following is substituted in lieu thereof (*Effective*
809 *October 1, 2011*):

810 (b) In accordance with the regulations adopted pursuant to section
811 38a-495a, [on and after July 1, 2005,] there [are] shall be standardized
812 Medicare supplement insurance policies or certificates as designated
813 [as plans "A" to "L", inclusive] by the Centers for Medicare and
814 Medicaid Services.

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

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

833 (b) Nothing in this section shall prohibit an insurance company,
834 fraternal benefit society, hospital service corporation, medical service
835 corporation, health care center or other entity in this state issuing
836 Medicare supplement insurance policies or certificates from using its
837 usual and customary underwriting procedures, provided no such
838 company, society, corporation, center or other entity shall issue a
839 Medicare supplement policy or certificate based on the age, gender,
840 previous claims history or the medical condition of the applicant. [,
841 except that the previous claims history and the medical condition of
842 the applicant may be used in determinations to grant coverage under
843 Medicare supplement policies and certificates issued prior to January
844 1, 2006, for plans "H" to "J", inclusive.]

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

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

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

863 (a) [Every] Each individual health insurance policy providing
864 coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11)
865 and (12) of section 38a-469, delivered_z [or] issued for delivery_z

866 renewed, amended or continued in this state more than one hundred
867 twenty days after July 1, 1971, [which] that provides that coverage of a
868 dependent child shall terminate upon attainment of the limiting age
869 for dependent children specified in the policy shall also provide in
870 substance that attainment of the limiting age shall not operate to
871 terminate the coverage of the child if at such date the child is and
872 continues thereafter to be both (1) incapable of self-sustaining
873 employment by reason of mental or physical handicap, as certified by
874 the child's physician on a form provided by the insurer, hospital or
875 medical service corporation or health care center, and (2) chiefly
876 dependent upon the policyholder or subscriber for support and
877 maintenance.

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

881 (a) Each group health insurance policy providing coverage of the
882 type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section
883 38a-469 delivered, [or] issued for delivery, renewed, amended or
884 continued in this state more than one hundred twenty days after July
885 1, 1971, [which] that provides that coverage of a dependent child of an
886 employee or other member of the covered group shall terminate upon
887 attainment of the limiting age for dependent children specified in the
888 policy shall also provide in substance that attainment of the limiting
889 age shall not operate to terminate the coverage of the child if at such
890 date the child is and continues thereafter to be both (1) incapable of
891 self-sustaining employment by reason of mental or physical handicap,
892 as certified by the child's physician on a form provided by the insurer,
893 hospital or medical service corporation, or health care center, and (2)
894 chiefly dependent upon such employee or member for support and
895 maintenance.

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

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

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

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

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

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

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

929 (a) Each group health insurance policy delivered, issued for
930 delivery, renewed, amended or continued in this state providing

931 coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and
932 (12) of section 38a-469 for a family member of the insured or subscriber
933 shall also provide as to such family members' coverage, that the health
934 insurance benefits applicable for children shall be payable with respect
935 to a newly born child of the insured or subscriber from the moment of
936 birth.

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

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

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

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

957 [Every] Each individual health insurance policy providing coverage
958 of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12)
959 of section 38a-469, delivered, issued for delivery, [or] renewed,
960 amended or continued in this state [on or after July 1, 1992,] shall
961 provide coverage for hypodermic needles or syringes prescribed by a
962 prescribing practitioner, as defined in subdivision (22) of section 20-

963 571, for the purpose of administering medications for medical
964 conditions, provided such medications are covered under the policy.
965 Such benefits shall be subject to any policy provisions that apply to
966 other services covered by such policy.

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

969 [Every] Each group health insurance policy providing coverage of
970 the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of
971 section 38a-469, delivered, issued for delivery, [or] renewed, amended
972 or continued in this state [on or after July 1, 1992,] shall provide
973 coverage for hypodermic needles or syringes prescribed by a
974 prescribing practitioner, as defined in subdivision (22) of section 20-
975 571, for the purpose of administering medications for medical
976 conditions, provided such medications are covered under the policy.
977 Such benefits shall be subject to any policy provisions that apply to
978 other services covered by such policy.

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

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

996 (AHFS-DI).

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

1000 (a) Each group health insurance policy delivered, issued for
1001 delivery, ~~or~~ renewed, amended or continued in this state [on or after
1002 October 1, 1994, which] that provides coverage for prescribed drugs
1003 approved by the federal Food and Drug Administration for treatment
1004 of certain types of cancer shall not exclude coverage of any such drug
1005 on the basis that such drug has been prescribed for the treatment of a
1006 type of cancer for which the drug has not been approved by the federal
1007 Food and Drug Administration, provided the drug is recognized for
1008 treatment of the specific type of cancer for which the drug has been
1009 prescribed in one of the following established reference compendia: (1)
1010 The U.S. Pharmacopoeia Drug Information Guide for the Health Care
1011 Professional (USP DI); (2) The American Medical Association's Drug
1012 Evaluations (AMA DE); or (3) The American Society of Hospital
1013 Pharmacists' American Hospital Formulary Service Drug Information
1014 (AHFS-DI).

1015 Sec. 41. Subsection (a) of section 38a-493 of the general statutes is
1016 repealed and the following is substituted in lieu thereof (*Effective*
1017 *January 1, 2012*):

1018 (a) ~~[Every]~~ Each individual health insurance policy providing
1019 coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11)
1020 and (12) of section 38a-469 delivered, issued for delivery, ~~or~~ renewed,
1021 amended or continued in this state [on or after October 1, 1975,] shall
1022 provide coverage providing reimbursement for home health care to
1023 residents in this state.

1024 Sec. 42. Subsection (a) of section 38a-520 of the general statutes is
1025 repealed and the following is substituted in lieu thereof (*Effective*
1026 *January 1, 2012*):

1027 (a) Each group health insurance policy providing coverage of the
1028 type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section
1029 38a-469 delivered, issued for delivery, [or] renewed, amended or
1030 continued in this state [on or after October 1, 1975,] shall provide
1031 coverage providing reimbursement for home health care to residents
1032 in this state.

1033 Sec. 43. Subsection (j) of section 38a-493 of the general statutes is
1034 repealed and the following is substituted in lieu thereof (*Effective*
1035 *January 1, 2012*):

1036 (j) [Every] Each individual major medical expense policy delivered,
1037 issued for delivery, [or] renewed, amended or continued in this state
1038 [on or after October 1, 1989,] shall provide coverage in accordance with
1039 the provisions of this section for home health care to residents in this
1040 state whose benefits are no longer provided under Medicare or any
1041 applicable individual health insurance policy.

1042 Sec. 44. Subsection (j) of section 38a-520 of the general statutes is
1043 repealed and the following is substituted in lieu thereof (*Effective*
1044 *January 1, 2012*):

1045 (j) Each major medical expense policy delivered, issued for delivery,
1046 [or] renewed, amended or continued in this state [on or after October
1047 1, 1989,] shall provide coverage in accordance with the provisions of
1048 this section for home health care to residents in this state whose
1049 benefits are no longer provided under Medicare or any applicable
1050 individual or group health insurance policy.

1051 Sec. 45. Subsection (b) of section 38a-496 of the general statutes is
1052 repealed and the following is substituted in lieu thereof (*Effective*
1053 *January 1, 2012*):

1054 (b) [Every] Each individual health insurance policy providing
1055 coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11)
1056 and (12) of section 38a-469 delivered, issued for delivery, [or] renewed,
1057 amended or continued in this state [on or after October 1, 1982, which]

1058 that provides coverage for expenses incurred for physical therapy shall
1059 provide coverage for occupational therapy provided in private practice
1060 or in a health care facility or in a partial hospitalization program on an
1061 exchange basis.

1062 Sec. 46. Subsection (b) of section 38a-524 of the general statutes is
1063 repealed and the following is substituted in lieu thereof (*Effective*
1064 *January 1, 2012*):

1065 (b) Each group health insurance policy providing coverage of the
1066 type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section
1067 38a-469 delivered, issued for delivery, [or] renewed, amended or
1068 continued in this state [on or after October 1, 1982, which] that
1069 provides coverage for expenses incurred for physical therapy shall
1070 provide coverage for occupational therapy provided in private practice
1071 or in a health care facility or in a partial hospitalization program on an
1072 exchange basis.

1073 Sec. 47. Subsection (b) of section 38a-499 of the general statutes is
1074 repealed and the following is substituted in lieu thereof (*Effective*
1075 *January 1, 2012*):

1076 (b) [Every] Each individual health insurance policy providing
1077 coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11)
1078 and (12) of section 38a-469 delivered, issued for delivery, [or] renewed,
1079 amended or continued in this state [on or after October 1, 1984,] shall
1080 provide coverage for the services of physician assistants, certified
1081 nurse practitioners, certified psychiatric-mental health clinical nurse
1082 specialists and certified nurse-midwives if such services are within the
1083 individual's area of professional competence as established by
1084 education and licensure or certification and are currently reimbursed
1085 when rendered by any other licensed health care provider. Subject to
1086 the provisions of chapter 378 and sections 20-86a to 20-86e, inclusive,
1087 no insurer, hospital [or] service corporation, medical service
1088 corporation or health care center may require signature, referral or
1089 employment by any other health care provider as a condition of
1090 reimbursement, provided no insurer, hospital [or] service corporation,

1091 medical service corporation or health care center may be required to
1092 pay for duplicative services actually rendered by both a physician
1093 assistant or a certified registered nurse and any other health care
1094 provider. The payment of such benefits shall be subject to any policy
1095 provisions which apply to other licensed health practitioners
1096 providing the same services. Nothing in this section may be construed
1097 as permitting (1) any registered nurse to perform or provide services
1098 beyond the scope of practice permitted in chapter 378 and sections 20-
1099 86a to 20-86e, inclusive, or (2) any physician assistant to perform or
1100 provide services beyond the scope of practice permitted in chapter 370.

1101 Sec. 48. Subsection (b) of section 38a-526 of the general statutes is
1102 repealed and the following is substituted in lieu thereof (*Effective*
1103 *January 1, 2012*):

1104 (b) Each group health insurance policy providing coverage of the
1105 type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section
1106 38a-469 delivered, issued for delivery, [or] renewed, amended or
1107 continued in this state [on or after October 1, 1984,] shall provide
1108 coverage for the services of physician assistants, certified nurse
1109 practitioners, certified psychiatric-mental health clinical nurse
1110 specialists and certified nurse-midwives if such services are within the
1111 individual's area of professional competence as established by
1112 education and licensure or certification and are currently reimbursed
1113 when rendered by any other licensed health care provider. Subject to
1114 the provisions of chapter 378 and sections 20-86a to 20-86e, inclusive,
1115 no insurer, hospital [or] service corporation, medical service
1116 corporation or health care center may require signature, referral or
1117 employment by any other health care provider as a condition of
1118 reimbursement, provided no insurer, hospital [or] service corporation,
1119 medical service corporation or health care center may be required to
1120 pay for duplicative services actually rendered by both a physician
1121 assistant or a certified registered nurse and any other health care
1122 provider. The payment of such benefits shall be subject to any policy
1123 provisions which apply to other licensed health practitioners
1124 providing the same services. Nothing in this section may be construed

1125 as permitting (1) any registered nurse to perform or provide services
1126 beyond the scope of practice permitted in chapter 378 and sections 20-
1127 86a to 20-86e, inclusive, or (2) any physician assistant to perform or
1128 provide services beyond the scope of practice permitted in chapter 370.

1129 Sec. 49. Subsection (a) of section 38a-503b of the general statutes is
1130 repealed and the following is substituted in lieu thereof (*Effective*
1131 *January 1, 2012*):

1132 (a) As used in this section, "carrier" means each insurer, health care
1133 center, hospital [and] service corporation, medical service corporation
1134 or other entity delivering, issuing for delivery, renewing, [or]
1135 amending or continuing any individual health insurance policy in this
1136 state [on or after October 1, 1995,] providing coverage of the type
1137 specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section
1138 38a-469.

1139 Sec. 50. Subsection (a) of section 38a-530b of the general statutes is
1140 repealed and the following is substituted in lieu thereof (*Effective*
1141 *January 1, 2012*):

1142 (a) As used in this section, "carrier" means each insurer, health care
1143 center, hospital [and] service corporation, medical service corporation
1144 [.] or other entity delivering, issuing for delivery, renewing, [or]
1145 amending or continuing any group health insurance policy in this state
1146 [on or after October 1, 1995,] providing coverage of the type specified
1147 in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469.

1148 Sec. 51. Subsection (a) of section 38a-503c of the general statutes is
1149 repealed and the following is substituted in lieu thereof (*Effective*
1150 *January 1, 2012*):

1151 (a) As used in this section, "carrier" means each insurer, health care
1152 center, hospital [and] service corporation, medical service corporation
1153 [.] or other entity delivering, issuing for delivery, renewing, [or]
1154 amending or continuing any individual health insurance policy in this
1155 state [on or after October 1, 1996,] providing coverage of the type

1156 specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section
1157 38a-469.

1158 Sec. 52. Subsection (a) of section 38a-530c of the general statutes is
1159 repealed and the following is substituted in lieu thereof (*Effective*
1160 *January 1, 2012*):

1161 (a) As used in this section, "carrier" means each insurer, health care
1162 center, hospital [and] service corporation, medical service corporation
1163 [] or other entity delivering, issuing for delivery, renewing, [or]
1164 amending or continuing any group health insurance policy in this state
1165 [on or after October 1, 1996,] providing coverage of the type specified
1166 in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469.

1167 Sec. 53. Subsection (a) of section 38a-503e of the general statutes is
1168 repealed and the following is substituted in lieu thereof (*Effective*
1169 *January 1, 2012*):

1170 (a) Each individual health insurance policy providing coverage of
1171 the type specified in subdivisions (1), (2), (4), (11) and (12) of section
1172 38a-469 delivered, issued for delivery, renewed, amended or continued
1173 in this state [on or after October 1, 1999,] that provides coverage for
1174 outpatient prescription drugs approved by the federal Food and Drug
1175 Administration shall not exclude coverage for prescription
1176 contraceptive methods approved by the federal Food and Drug
1177 Administration.

1178 Sec. 54. Subsection (a) of section 38a-530e of the general statutes is
1179 repealed and the following is substituted in lieu thereof (*Effective*
1180 *January 1, 2012*):

1181 (a) Each group health insurance policy providing coverage of the
1182 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
1183 469 delivered, issued for delivery, renewed, amended or continued in
1184 this state [on or after October 1, 1999,] that provides coverage for
1185 outpatient prescription drugs approved by the federal Food and Drug
1186 Administration shall not exclude coverage for prescription

1187 contraceptive methods approved by the federal Food and Drug
1188 Administration.

1189 Sec. 55. Section 38a-507 of the general statutes is repealed and the
1190 following is substituted in lieu thereof (*Effective January 1, 2012*):

1191 [Every] Each individual health insurance policy delivered, issued
1192 for delivery, [or] renewed, amended or continued in this state [on or
1193 after October 1, 1989,] shall provide coverage for services rendered by
1194 a chiropractor licensed under chapter 372 to the same extent coverage
1195 is provided for services rendered by a physician, if such chiropractic
1196 services (1) treat a condition covered under such policy, and (2) are
1197 within those services a chiropractor is licensed to perform.

1198 Sec. 56. Section 38a-534 of the general statutes is repealed and the
1199 following is substituted in lieu thereof (*Effective January 1, 2012*):

1200 [Every] Each group health insurance policy providing coverage of
1201 the type specified in subdivisions (1), (2), (4), (6) and (11) of section
1202 38a-469, delivered, issued for delivery, [or] renewed, amended or
1203 continued in this state [on or after October 1, 1989,] shall provide
1204 coverage for services rendered by a chiropractor licensed under
1205 chapter 372 to the same extent coverage is provided for services
1206 rendered by a physician, if such chiropractic services (1) treat a
1207 condition covered under such policy, and (2) are within those services
1208 a chiropractor is licensed to perform.

1209 Sec. 57. Section 38a-504a of the general statutes is repealed and the
1210 following is substituted in lieu thereof (*Effective January 1, 2012*):

1211 Each individual health insurance policy providing coverage of the
1212 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
1213 469 delivered, issued for delivery, [or] renewed, amended or continued
1214 in this state [on or after January 1, 2002,] shall provide coverage for the
1215 routine patient care costs, as defined in section 38a-504d, as amended
1216 by this act, associated with cancer clinical trials, in accordance with
1217 sections 38a-504b to 38a-504g, inclusive, as amended by this act. As

1218 used in this section and sections 38a-504b to 38a-504g, inclusive, as
1219 amended by this act, "cancer clinical trial" means an organized,
1220 systematic, scientific study of therapies, tests or other clinical
1221 interventions for purposes of treatment or palliation or therapeutic
1222 intervention for the prevention of cancer in human beings. [except
1223 that a clinical trial for the prevention of cancer is eligible for coverage
1224 only if it involves a therapeutic intervention and is a phase III clinical
1225 trial approved by one of the entities identified in section 38a-504b and
1226 is conducted at multiple institutions.]

1227 Sec. 58. Section 38a-504b of the general statutes is repealed and the
1228 following is substituted in lieu thereof (*Effective January 1, 2012*):

1229 A clinical trial for the prevention of cancer shall be eligible for
1230 coverage only if it involves a therapeutic intervention, is a phase III
1231 clinical trial approved by one of the entities identified in this section,
1232 and is conducted at multiple institutions. In order to be eligible for
1233 coverage of routine patient care costs, as defined in section 38a-504d,
1234 as amended by this act, a cancer clinical trial shall be conducted under
1235 the auspices of an independent peer-reviewed protocol that has been
1236 reviewed and approved by: (1) One of the National Institutes of
1237 Health; or (2) a National Cancer Institute affiliated cooperative group;
1238 or (3) the federal Food and Drug Administration as part of an
1239 investigational new drug or device exemption; or (4) the federal
1240 Department of Defense or Veterans Affairs. Nothing in sections 38a-
1241 504a to 38a-504g, inclusive, as amended by this act, shall be construed
1242 to require coverage for any single institution cancer clinical trial
1243 conducted solely under the approval of the institutional review board
1244 of an institution, or any trial that is no longer approved by an entity
1245 identified in subdivision (1), (2), (3) or (4) of this section.

1246 Sec. 59. Section 38a-504c of the general statutes is repealed and the
1247 following is substituted in lieu thereof (*Effective January 1, 2012*):

1248 In order to be eligible for coverage of routine patient care costs, as
1249 defined in section 38a-504d, as amended by this act, the insurer, health
1250 care center or plan administrator may require that the person or entity

1251 seeking coverage for the cancer clinical trial provide: (1) Evidence
1252 satisfactory to the insurer, health care center or plan administrator that
1253 the insured person receiving coverage meets all of the patient selection
1254 criteria for the cancer clinical trial, including credible evidence in the
1255 form of clinical or preclinical data showing that the cancer clinical trial
1256 is likely to have a benefit for the insured person that is commensurate
1257 with the risks of participation in the cancer clinical trial to treat the
1258 person's condition; [and] (2) evidence that the appropriate informed
1259 consent has been received from the insured person; [and] (3) copies of
1260 any medical records, protocols, test results or other clinical information
1261 used by the physician or institution seeking to enroll the insured
1262 person in the cancer clinical trial; [and] (4) a summary of the
1263 anticipated routine patient care costs in excess of the costs for standard
1264 treatment; [and] (5) information from the physician or institution
1265 seeking to enroll the insured person in the clinical trial regarding those
1266 items, including any routine patient care costs, that are eligible for
1267 reimbursement by an entity other than the insurer or health care
1268 center, including the entity sponsoring the clinical trial; and (6) any
1269 additional information that may be reasonably required for the review
1270 of a request for coverage of the cancer clinical trial. The health plan or
1271 insurer shall request any additional information about a cancer clinical
1272 trial [within] not later than five business days [of] after receiving a
1273 request for coverage from an insured person or a physician seeking to
1274 enroll an insured person in a cancer clinical trial. Nothing in sections
1275 38a-504a to 38a-504g, inclusive, as amended by this act, shall be
1276 construed to require the insurer or health care center to provide
1277 coverage for routine patient care costs that are eligible for
1278 reimbursement by an entity other than the insurer, including the entity
1279 sponsoring the cancer clinical trial.

1280 Sec. 60. Subsection (a) of section 38a-504d of the general statutes is
1281 repealed and the following is substituted in lieu thereof (*Effective*
1282 *January 1, 2012*):

1283 (a) For purposes of sections 38a-504a to 38a-504g, inclusive, as
1284 amended by this act, "routine patient care costs" means: (1) [Coverage

1285 for medically] Medically necessary health care services that are
1286 incurred as a result of the treatment being provided to the insured
1287 person for purposes of the cancer clinical trial that would otherwise be
1288 covered if such services were not rendered pursuant to a cancer
1289 clinical trial. Such services shall include those rendered by a physician,
1290 diagnostic or laboratory tests, hospitalization or other services
1291 provided to the [patient] insured person during the course of
1292 treatment in the cancer clinical trial for a condition, or one of its
1293 complications, that is consistent with the usual and customary
1294 standard of care and would be covered if the insured person were not
1295 enrolled in a cancer clinical trial. Such hospitalization shall include
1296 treatment at an out-of-network facility if such treatment is not
1297 available in-network and not eligible for reimbursement by the
1298 sponsors of such clinical trial; and (2) [coverage for routine patient
1299 care] costs incurred for drugs provided to the insured person, in
1300 accordance with section [38a-518b] 38a-492b, as amended by this act,
1301 provided such drugs have been approved for sale by the federal Food
1302 and Drug Administration.

1303 Sec. 61. Subsection (b) of section 38a-504f of the general statutes is
1304 repealed and the following is substituted in lieu thereof (*Effective*
1305 *January 1, 2012*):

1306 (b) Any insurer or health care center that receives the department
1307 form from a provider, hospital or institution seeking coverage for the
1308 routine patient care costs of an insured person in a cancer clinical trial
1309 shall approve or deny coverage for such services [within] not later than
1310 five business days [of] after receiving such request and any other
1311 reasonable supporting materials requested by the insurer or health
1312 plan pursuant to section 38a-504c, as amended by this act, except that
1313 an insurer or health care center that utilizes independent experts to
1314 review such requests shall respond [within] not later than ten business
1315 days after receiving such request and supporting materials. Requests
1316 for coverage of phase III clinical trials for the prevention of cancer
1317 pursuant to section [38a-504a] 38a-504b, as amended by this act, shall
1318 be approved or denied [within] not later than fourteen business days

1319 after receiving such request and supporting materials.

1320 Sec. 62. Section 38a-542a of the general statutes is repealed and the
1321 following is substituted in lieu thereof (*Effective January 1, 2012*):

1322 Each group health insurance policy providing coverage of the type
1323 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
1324 delivered, issued for delivery, [or] renewed, amended or continued in
1325 this state [on or after January 1, 2002,] shall provide coverage for the
1326 routine patient care costs, as defined in section 38a-542d, as amended
1327 by this act, associated with cancer clinical trials, in accordance with
1328 sections 38a-542b to 38a-542g, inclusive, as amended by this act. As
1329 used in this section and sections 38a-542b to 38a-542g, inclusive, as
1330 amended by this act, "cancer clinical trial" means an organized,
1331 systematic, scientific study of therapies, tests or other clinical
1332 interventions for purposes of treatment or palliation or therapeutic
1333 intervention for the prevention of cancer in human beings. [, except
1334 that a clinical trial for the prevention of cancer is eligible for coverage
1335 only if it involves a therapeutic intervention and is a phase III clinical
1336 trial approved by one of the entities identified in section 38a-542b and
1337 is conducted at multiple institutions.]

1338 Sec. 63. Section 38a-542b of the general statutes is repealed and the
1339 following is substituted in lieu thereof (*Effective January 1, 2012*):

1340 A clinical trial for the prevention of cancer shall be eligible for
1341 coverage only if it involves a therapeutic intervention, is a phase III
1342 clinical trial approved by one of the entities identified in this section,
1343 and is conducted at multiple institutions. In order to be eligible for
1344 coverage of routine patient care costs, as defined in section 38a-542d,
1345 as amended by this act, a cancer clinical trial shall be conducted under
1346 the auspices of an independent peer-reviewed protocol that has been
1347 reviewed and approved by: (1) One of the National Institutes of
1348 Health; or (2) a National Cancer Institute affiliated cooperative group;
1349 or (3) the federal Food and Drug Administration as part of an
1350 investigational new drug or device exemption; or (4) the federal
1351 Department of Defense or Veterans Affairs. Nothing in sections 38a-

1352 542a to 38a-542g, inclusive, as amended by this act, shall be construed
1353 to require coverage for any single institution cancer clinical trial
1354 conducted solely under the approval of the institutional review board
1355 of an institution, or any trial that is no longer approved by an entity
1356 identified in subdivision (1), (2), (3) or (4) of this section.

1357 Sec. 64. Section 38a-542c of the general statutes is repealed and the
1358 following is substituted in lieu thereof (*Effective January 1, 2012*):

1359 In order to be eligible for coverage of routine patient care costs, as
1360 defined in section 38a-542d, as amended by this act, the insurer, health
1361 care center or plan administrator may require that the person or entity
1362 seeking coverage for the cancer clinical trial provide: (1) Evidence
1363 satisfactory to the insurer, health care center or plan administrator that
1364 the insured person receiving coverage meets all of the patient selection
1365 criteria for the cancer clinical trial, including credible evidence in the
1366 form of clinical or pre-clinical data showing that the cancer clinical trial
1367 is likely to have a benefit for the insured person that is commensurate
1368 with the risks of participation in the cancer clinical trial to treat the
1369 person's condition; [and] (2) evidence that the appropriate informed
1370 consent has been received from the insured person; [and] (3) copies of
1371 any medical records, protocols, test results or other clinical information
1372 used by the physician or institution seeking to enroll the insured
1373 person in the cancer clinical trial; [and] (4) a summary of the
1374 anticipated routine patient care costs in excess of the costs for standard
1375 treatment; [and] (5) information from the physician or institution
1376 seeking to enroll the insured person in the clinical trial regarding those
1377 items, including any routine patient care costs, that are eligible for
1378 reimbursement by an entity other than the insurer or health care
1379 center, including the entity sponsoring the clinical trial; and (6) any
1380 additional information that may be reasonably required for the review
1381 of a request for coverage of the cancer clinical trial. The health plan or
1382 insurer shall request any additional information about a cancer clinical
1383 trial [within] not later than five business days [of] after receiving a
1384 request for coverage from an insured person or a physician seeking to
1385 enroll an insured person in a cancer clinical trial. Nothing in sections

1386 38a-542a to 38a-542g, inclusive, as amended by this act, shall be
1387 construed to require the insurer or health care center to provide
1388 coverage for routine patient care costs that are eligible for
1389 reimbursement by an entity other than the insurer, including the entity
1390 sponsoring the cancer clinical trial.

1391 Sec. 65. Subsection (a) of section 38a-542d of the general statutes is
1392 repealed and the following is substituted in lieu thereof (*Effective*
1393 *January 1, 2012*):

1394 (a) For purposes of sections 38a-542a to 38a-542g, inclusive, as
1395 amended by this act, "routine patient care costs" means: (1) [Coverage
1396 for medically] Medically necessary health care services that are
1397 incurred as a result of the treatment being provided to the insured
1398 person for purposes of the cancer clinical trial that would otherwise be
1399 covered if such services were not rendered pursuant to a cancer
1400 clinical trial. Such services shall include those rendered by a physician,
1401 diagnostic or laboratory tests, hospitalization or other services
1402 provided to the [patient] insured person during the course of
1403 treatment in the cancer clinical trial for a condition, or one of its
1404 complications, that is consistent with the usual and customary
1405 standard of care and would be covered if the insured person were not
1406 enrolled in a cancer clinical trial. Such hospitalization shall include
1407 treatment at an out-of-network facility if such treatment is not
1408 available in-network and not eligible for reimbursement by the
1409 sponsors of such clinical trial; and (2) [coverage for routine patient
1410 care] costs incurred for drugs provided to the insured person, in
1411 accordance with section 38a-518b, as amended by this act, provided
1412 such drugs have been approved for sale by the federal Food and Drug
1413 Administration.

1414 Sec. 66. Subsection (b) of section 38a-542f of the general statutes is
1415 repealed and the following is substituted in lieu thereof (*Effective*
1416 *January 1, 2012*):

1417 (b) Any insurer or health care center that receives the department
1418 form from a provider, hospital or institution seeking coverage for the

1419 routine patient care costs of an insured person in a cancer clinical trial
 1420 shall approve or deny coverage for such services [within] not later than
 1421 five business days [of] after receiving such request and any other
 1422 reasonable supporting materials requested by the insurer or health
 1423 plan pursuant to section 38a-542c, as amended by this act, except that
 1424 an insurer or health care center that utilizes independent experts to
 1425 review such requests shall respond [within] not later than ten business
 1426 days after receiving such request and supporting materials. Requests
 1427 for coverage of phase III clinical trials for the prevention of cancer
 1428 pursuant to section [38a-542a] 38a-542b, as amended by this act, shall
 1429 be approved or denied [within] not later than fourteen business days
 1430 after receiving such request and supporting materials.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2011</i>	20-529a(d)
Sec. 2	<i>October 1, 2011</i>	38a-155(a)
Sec. 3	<i>October 1, 2011</i>	38a-155(e)
Sec. 4	<i>October 1, 2011</i>	38a-335(d)
Sec. 5	<i>October 1, 2011</i>	38a-430
Sec. 6	<i>October 1, 2011</i>	38a-457(e)(1)
Sec. 7	<i>October 1, 2011</i>	38a-472c
Sec. 8	<i>October 1, 2011</i>	38a-503d(a)
Sec. 9	<i>October 1, 2011</i>	38a-530d(a)
Sec. 10	<i>October 1, 2011</i>	38a-504(d)
Sec. 11	<i>October 1, 2011</i>	38a-542(d)
Sec. 12	<i>October 1, 2011</i>	38a-519(a) and (b)
Sec. 13	<i>October 1, 2011</i>	38a-546(a)
Sec. 14	<i>October 1, 2011</i>	38a-564
Sec. 15	<i>October 1, 2011</i>	38a-567(18)
Sec. 16	<i>October 1, 2011</i>	38a-686(b)(6)(D)(iii)
Sec. 17	<i>October 1, 2011</i>	38a-839
Sec. 18	<i>October 1, 2011</i>	38a-841(a) and (b)
Sec. 19	<i>October 1, 2011</i>	38a-843(c)
Sec. 20	<i>October 1, 2011</i>	38a-175(2)
Sec. 21	<i>October 1, 2011</i>	38a-482a
Sec. 22	<i>October 1, 2011</i>	38a-513c
Sec. 23	<i>October 1, 2011</i>	38a-483b

Sec. 24	<i>October 1, 2011</i>	38a-513a
Sec. 25	<i>October 1, 2011</i>	38a-491b
Sec. 26	<i>October 1, 2011</i>	38a-517b
Sec. 27	<i>October 1, 2011</i>	38a-473(b)
Sec. 28	<i>October 1, 2011</i>	38a-474(b)
Sec. 29	<i>October 1, 2011</i>	38a-481(c)
Sec. 30	<i>October 1, 2011</i>	38a-495b(b)
Sec. 31	<i>October 1, 2011</i>	38a-495c(a) and (b)
Sec. 32	<i>October 1, 2011</i>	38a-513(b)
Sec. 33	<i>January 1, 2012</i>	38a-489(a)
Sec. 34	<i>January 1, 2012</i>	38a-515(a)
Sec. 35	<i>January 1, 2012</i>	38a-490
Sec. 36	<i>January 1, 2012</i>	38a-516
Sec. 37	<i>January 1, 2012</i>	38a-492a
Sec. 38	<i>January 1, 2012</i>	38a-518a
Sec. 39	<i>January 1, 2012</i>	38a-492b(a)
Sec. 40	<i>January 1, 2012</i>	38a-518b(a)
Sec. 41	<i>January 1, 2012</i>	38a-493(a)
Sec. 42	<i>January 1, 2012</i>	38a-520(a)
Sec. 43	<i>January 1, 2012</i>	38a-493(j)
Sec. 44	<i>January 1, 2012</i>	38a-520(j)
Sec. 45	<i>January 1, 2012</i>	38a-496(b)
Sec. 46	<i>January 1, 2012</i>	38a-524(b)
Sec. 47	<i>January 1, 2012</i>	38a-499(b)
Sec. 48	<i>January 1, 2012</i>	38a-526(b)
Sec. 49	<i>January 1, 2012</i>	38a-503b(a)
Sec. 50	<i>January 1, 2012</i>	38a-530b(a)
Sec. 51	<i>January 1, 2012</i>	38a-503c(a)
Sec. 52	<i>January 1, 2012</i>	38a-530c(a)
Sec. 53	<i>January 1, 2012</i>	38a-503e(a)
Sec. 54	<i>January 1, 2012</i>	38a-530e(a)
Sec. 55	<i>January 1, 2012</i>	38a-507
Sec. 56	<i>January 1, 2012</i>	38a-534
Sec. 57	<i>January 1, 2012</i>	38a-504a
Sec. 58	<i>January 1, 2012</i>	38a-504b
Sec. 59	<i>January 1, 2012</i>	38a-504c
Sec. 60	<i>January 1, 2012</i>	38a-504d(a)
Sec. 61	<i>January 1, 2012</i>	38a-504f(b)
Sec. 62	<i>January 1, 2012</i>	38a-542a
Sec. 63	<i>January 1, 2012</i>	38a-542b
Sec. 64	<i>January 1, 2012</i>	38a-542c

Sec. 65	<i>January 1, 2012</i>	38a-542d(a)
Sec. 66	<i>January 1, 2012</i>	38a-542f(b)

Statement of Legislative Commissioners:

In section 53, "group" was changed to "individual" for accuracy.

INS *Joint Favorable Subst.-LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note***State Impact:*** None***Municipal Impact:*** None***Explanation***

This bill makes various technical and clarifying changes to the insurance statutes. There is no state or municipal fiscal impact.

The Out Years***State Impact:*** None***Municipal Impact:*** None

OLR Bill Analysis**sSB 849*****AN ACT CONCERNING THE LEGISLATIVE COMMISSIONERS' RECOMMENDATIONS FOR TECHNICAL REVISIONS AND MINOR CHANGES TO THE INSURANCE AND RELATED STATUTES.*****SUMMARY:**

This bill broadens the applicability of various health insurance benefit requirements. It also makes numerous technical changes in the insurance statutes.

EFFECTIVE DATE: January 1, 2012, except for some technical changes, which are effective October 1, 2011.

HEALTH INSURANCE BENEFITS

The bill broadens the applicability of various health insurance benefits required by law, as summarized in Table 1. By doing so, the bill applies the listed benefit requirements to individual and group health insurance policies delivered, issued, renewed, amended, or continued in the state. Most of the provisions apply to (1) individual and group health insurance policies that cover (a) basic hospital expenses; (b) basic medical-surgical expenses; (c) major medical expenses; or (d) hospital or medical services, including coverage under an HMO plan and (2) individual health insurance policies that cover limited benefits. (Due to federal law (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.)

Table 1: Applicability of Health Insurance Benefits Expanded

Bill §	Benefit Requirement	Law Applies to Policies	Bill Expands Law to Apply to Policies
33-34	Continuation of coverage of handicapped children	Delivered, Issued	Renewed, Amended, Continued
35-36	Coverage of newly born child	Delivered, Issued, Renewed, Amended	Continued
37-38	Coverage for hypodermic needles and syringes	Delivered, Issued, Renewed	Amended, Continued
39-40	Coverage for off-label prescription drugs	Delivered, Issued, Renewed	Amended, Continued
41-44	Coverage for home health care services	Delivered, Issued, Renewed	Amended, Continued
45-46	Coverage for occupational therapy	Delivered, Issued, Renewed	Amended, Continued
47-48	Coverage for services of physician assistants and certain nurses	Delivered, Issued, Renewed	Amended, Continued
49-50	Direct access to obstetrician-gynecologist	Delivered, Issued, Renewed, Amended	Continued
51-52	Coverage for maternity care	Delivered, Issued, Renewed, Amended	Continued
53-54	Coverage for prescription contraceptives	Delivered, Issued, Renewed, Continued	Amended
55-56	Coverage for chiropractic services	Delivered, Issued, Renewed	Amended, Continued
57 and 62	Coverage for cancer clinical trials	Delivered, Issued, Renewed	Amended, Continued

BACKGROUND

Related Bill

The Insurance and Real Estate Committee reported out SB 21, which expands the current requirement for health insurance policies to cover cancer clinical trials. It requires policies delivered, issued, renewed, amended, or continued in the state to cover costs associated with clinical trials for the treatment of disabling, progressive, or life-threatening medical conditions.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 19 Nay 0 (02/10/2011)