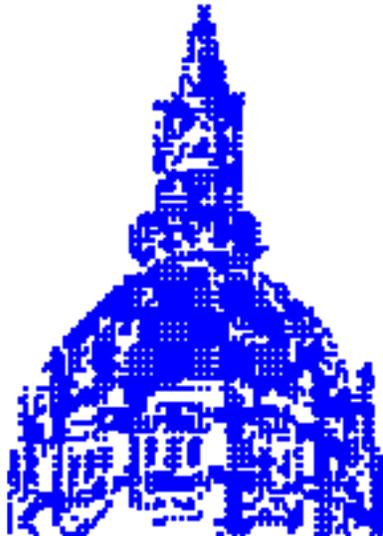


Office of Legislative Research
Connecticut General Assembly



OLR ACTS AFFECTING

INSURANCE



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NOTICE TO READERS

This report provides brief highlights of new laws affecting insurance enacted during the 2007 regular and special session. Each summary indicates the public act (PA) number and effective date.

Not all provisions of the acts are included here. Complete summaries of all 2007 public acts will be available in the fall when OLR's Public Act Summary book is published; some are already on OLR's website (www.cga.ct.gov/olr/OLRPASums.asp).

Readers are encouraged to obtain the full text of acts that interest them from the Connecticut State Library, House Clerk's Office, or General Assembly's website (www.cga.ct.gov/).

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HEALTH INSURANCE

Charter Oak Health Plan

PA 07-2, JSS (§ 23)

establishes a Charter Oak Health Plan for residents who have been uninsured for at least six months and are ineligible for publicly funded health care. It requires cost sharing for plan participants, such as monthly premiums; annual deductibles; coinsurance; tiered co-payments for prescription drugs, depending on whether the drug is on a formulary, is a brand name, or whether it is mail-ordered; a copay for nonemergency visits to the emergency department; and a lifetime benefit limit. It establishes a premium assistance program for residents whose income is less than 300% of FPL.

The act requires the social services commissioner to determine minimum requirements for the plan's amount, duration, and scope of benefits, which cannot include a pre-existing condition exclusion. It authorizes the commissioner to contract with any of the following entities to provide coverage: (1) managed care organizations, (2) a consortium of federally qualified health centers and other state-funded, community-based health care providers; and (3) other health care provider consortia established to serve plan participants. It specifies that the

consortia are not subject to the laws governing MCOs, hospital service corporations, and medical service corporations, including laws regarding annual financial filings with and rate approvals from the Connecticut Insurance Department.

EFFECTIVE DATE: July 1, 2008

Coverage for Clinical Trial Out-of-Network Hospitalization

PA 07-67 specifies that the coverage for medically necessary hospital services associated with certain cancer clinical trials under individual and group health insurance policies required by law includes treatment at an out-of-network facility if (1) the treatment is unavailable at an in-network facility and (2) the clinical trial sponsors are not paying for it. The act requires the out-of-network hospital and insurer or HMO to make the out-of-network hospital treatment available at no greater cost to the patient than if treatment was available at an in-network facility.

EFFECTIVE DATE: Upon passage

Coverage for Lead Screening

PA 07-2, JSS (§§ 51 & 52), requires health insurance policies to provide coverage for blood lead screening and risk assessments ordered by primary

care providers in accordance with section 48 of the act.

EFFECTIVE DATE: January 1, 2009

Coverage for Mobile Field Hospitals

PA 07-252 (§§ 68-71) changes the name of critical access hospitals to mobile field hospitals. By law, health insurance policies must provide coverage for such hospitals. The act defines a mobile field hospital as a modular, transportable facility used intermittently, deployed at the discretion of the Governor or her designee, to provide medical services at a mass gathering; for training or, in the event of a public health or other emergency, for isolation care purposes or triage and treatment during a mass casualty event; or for providing surge capacity for a hospital during a mass casualty event or infrastructure failure.

By law, health insurance policies must provide benefits for isolation care and emergency services provided by such hospitals. Such benefits are subject to any policy provisions that apply to other covered services. The rates a policy pays must be equal to the rates Medicaid pays, as determined by the Department of Social Services (DSS).

EFFECTIVE DATE: Upon passage

Coverage for Specialized Formulas

PA 07-197 requires health insurance policies to cover medically necessary specialized formulas administered under a physician's direction for children up to age 12, instead of age eight.

EFFECTIVE DATE: October 1, 2007

Dependent Children

PA 07-185 (§§ 15-17), as amended by **PA 07-2, JSS** (§§ 64, 65, & 69), extends, from age 22 to 26, the age to which group comprehensive and individual health insurance policies that cover children must do so. The act eliminates the requirements that children be dependent or full-time students.

EFFECTIVE DATE: July 1, 2007 (PA 07-2, JSS, makes these changes effective January 1, 2009)

Healthfirst Connecticut Authority

PA 07-185 (§ 30), as amended by **PA 07-2, JSS** (§ 67), establishes the Healthfirst Connecticut Authority to evaluate and make recommendations about health care in Connecticut, including how to contain costs, improve quality, and increase access. The panel must report its recommendations, including recommended strategies for increasing health care access, by

December 1, 2008, to the Public Health, Human Services, and Insurance committees.

Legislative leaders and the governor appoint 10 members, some of whom must represent specific interests. The public health and social services commissioners and the comptroller, or their designees, are ex-officio, nonvoting members. (PA 07-2, JSS, adds the insurance commissioner and health care advocate as ex-officio, nonvoting members.) All members must be familiar with the Institute of Medicine's health care reform principles and be committed to making recommendations consistent with them. The authority can apply for grants or financial assistance from state and federal agencies, individuals, groups, and corporations. The act appropriates \$500,000 to the public health department in FY 09 for the authority. (PA 07-2, JSS, removes the appropriation).

EFFECTIVE DATE: Upon passage, except for the appropriation, which is effective July 1, 2008.

HMO Deposits; Hold Harmless

PA 07-178 requires an HMO to deposit \$500,000 with the insurance commissioner or designated trustee, who must use the deposit to provide health care services to the HMO's enrollees if the HMO is placed in receivership and may use them for related administrative costs.

By law, an HMO may provide out-of-network (OON) benefits to its enrollees, subject to certain financial requirements. Prior law prohibited these benefits from exceeding 10% of its total quarterly health care expenditures (i.e., claims and expenses). The act instead permits OON benefits to exceed 10% of total expenditures if the HMO first (1) obtains the insurance commissioner's approval and (2) deposits an amount equal to at least 120% of its uncovered expenditures with the commissioner or designated trustee.

Prior law required contracts between an HMO and a contracted health care provider to specify that if the HMO failed to pay the provider, the enrollee would not be liable for the amount the HMO owed. The act instead requires the contract to include language it specifies that holds enrollees harmless (i.e., not liable) for amounts the HMO owes. It also requires the contract to inform the provider that it is an unfair trade practice to (1) ask an enrollee for more than his or her copayment or deductible or (2) report an enrollee to a credit agency for not paying a bill for which the HMO is liable.

EFFECTIVE DATE: October 1, 2007

Limited Benefits Plan

PA 07-96, beginning January 1, 2008, requires each individual and group health insurance policy, contract, or certificate issued in Connecticut that provides limited coverage, and any related advertising, marketing, and enrollment material, to include a conspicuous statement disclosing that the plan does not provide comprehensive medical coverage.

It also prohibits, as of that date, an insurer, HMO, or other entity from replacing an employer-sponsored comprehensive health insurance plan with a policy that provides limited coverage.

EFFECTIVE DATE: July 1, 2007

Long-Term Care Policy Elimination Period

PA 07-226 changes the elimination period required under a long-term care insurance policy. Prior law required a “reasonable” elimination period (i.e., a waiting period after the onset of the injury, illness, or function loss during which no benefits are payable). The act instead requires an elimination period that is (1) up to 100 days of confinement or (2) between 100 days and two years of confinement if an irrevocable trust is in place that is estimated to be sufficient to cover the person’s confinement costs during this period.

The act requires that the trust (1) pay the health care provider directly and (2) create an unconditional duty to pay only confinement costs during the elimination period. It specifies that the (1) state, grantor, or person acting on the grantor’s behalf may enforce this duty and (2) trust remains subject to taxes and any trustee charges allowed by law.

For policies that offer the elimination period trust option, the act requires an insurer to include, (1) in rate filings it submits to the insurance commissioner, how it estimated trust values and (2) on the policy application and face page, a clear and conspicuous statement that the trust may be insufficient to cover all costs incurred during the elimination period.

EFFECTIVE DATE: October 1, 2007

Long-Term Care Policy Nonforfeiture Benefit

PA 07-28 prohibits an insurer from issuing or delivering a long-term care policy on or after July 1, 2008 unless it had offered the prospective insured an optional nonforfeiture benefit during the policy solicitation or application process. If the nonforfeiture option is declined, the insurer must give the insured a contingent benefit if the policy lapses (i.e., terminates because the insured stops paying the premium). The contingent benefit must be available to the insured

for a period of time after any substantial premium increase.

The act requires the insurance commissioner to adopt regulations by July 1, 2008 to implement the nonforfeiture option and contingent benefit requirements.

The act's requirements apply to insurance companies, fraternal benefit societies, hospital or medical service corporations, and HMOs.

EFFECTIVE DATE: July 1, 2007

Medicaid and Pharmacy Claims

PA 07-2, JSS (§ 21), prohibits any pharmacy from claiming payment from DSS under a DSS-administered medical assistance program or the Medicare Part D Supplemental Needs Fund for drugs prescribed to people who have other prescription drug insurance coverage unless the coverage has been exhausted and the person is otherwise eligible for the program or assistance from the Fund. It requires DSS to recoup from the submitting pharmacy any claims it submitted to DSS that DSS paid when other insurance coverage is available.

EFFECTIVE DATE: Upon passage

Medicaid and Third Party Coverage

PA 07-2, JSS (§§ 18-20), requires a health insurer, including a self-insured plan, and any other entity party that is, by statute, contract, or agreement, legally responsible for paying health care claims to provide the social services commissioner, upon request, information to identify, determine, or establish third-party coverage.

With respect to individuals who are eligible for or receiving Medicaid, the act requires health insurers, as a condition of operating in Connecticut, to:

1. provide to the DSS commissioner, all third-party administrators, PBMs, dental benefits managers, and other entities with which the insurer arranges to adjudicate health care claims any information the commissioner or his designee prescribes that is necessary for determining whether there is available coverage and the coverage plan's name, address, and identifying number;
2. accept the state's right of recovery and a person's assignment of benefits to the state for payment of a health care service provided for which Medicaid paid;
3. respond to any inquiry from the commissioner or

- his designee regarding a health care claim submitted within three years from the date the service was provided; and
4. agree not to deny a claim that the state submits solely based on its submission date, claim form, type or format, or failure to present proper documentation at the “point-of-sale” that is the basis of the claim if (a) the state or its agent submits the claim within the three-year period and (b) the state begins any legal action to enforce its rights with respect to the claim within six years of the claim submission.

EFFECTIVE DATE: July 1, 2007

Medical Necessity; External Appeals

PA 07-75 requires insurers, HMOs, and other entities to include the definition of “medically necessary” or “medical necessity” it specifies in individual and group health insurance policies and contracts. The requirement does not apply to insurers and HMOs that entered into a federal court-approved class action settlement with physicians until the settlement’s expiration date.

The act extends the timeframe for appealing to the insurance commissioner (i.e., filing an external appeal) after a person

has exhausted a company’s internal grievance procedures from 30 days to 60 days.

EFFECTIVE DATE: January 1, 2008, except for the appeal provision, which is effective upon passage.

Medicare Supplement Prepaid Premium

PA 07-48 requires insurers to refund to a person who cancels his or her Medicare supplement policy before the policy’s coverage period ends any prepaid premium. The requirement applies to insurance companies, fraternal benefit societies, hospital or medical service corporations, HMOs, and other entities that deliver, issue, continue, or renew a Medicare supplement policy or certificate in Connecticut.

EFFECTIVE DATE: October 1, 2007

Pharmacy Benefit Managers

PA 07-200 requires pharmacy benefit managers (PBMs), with exceptions, to obtain a certificate of registration from the Insurance Department before operating in Connecticut. It requires PBMs already operating in the state on January 1, 2008 to obtain one by April 1, 2008 to continue operating here.

PBMs must apply for registration by giving the department (1) a completed application form that contains information on the people

running the PBM; (2) a nonrefundable \$50 fee; and (3) evidence of a surety bond that is between \$25,000 and \$1 million. The PBM may request a hearing if the department denies registration. The act permits the insurance commissioner to suspend, revoke, or deny registration for specified causes after notice and hearing. PBMs must apply annually for registration renewal.

The act exempts from the registration requirement a PBM that is a line of business or affiliate of a Connecticut-licensed health insurer, HMO, hospital or medical service corporation, or fraternal benefit society. It requires the insurer or other entity to annually notify the insurance commissioner in writing on a department form that it is affiliated with or operating a PBM.

The act also excludes a PBM that processes pharmacy claims primarily to administer a health benefit plan's pharmacy benefit from the "preferred provider network" (PPN) definition; thus, the PBM does not have to obtain a PPN license or comply with state PPN requirements.

EFFECTIVE DATE: January 1, 2008

Post-Claims Underwriting; Preexisting Conditions

PA 07-113 prohibits certain health insurers and HMOs from rescinding, canceling, or limiting coverage based on information a person submitted with or omitted from an insurance application if, before issuing the policy, contract, or certificate, the insurer or HMO did not perform a thorough medical underwriting process. This includes resolving all reasonable medical questions based on the written application.

However, the act allows a rescission, cancellation, or limitation based on the application when the insurance commissioner approves it. It requires insurers and HMOs to apply for approval using a process it specifies. It permits the commissioner to approve the action if the enrollee, or the enrollee's representative, knew or should have known that information material to the insurer's or HMO's risk assumption was (1) false when included with the application or (2) omitted from the application. Regardless, it prohibits an insurer or HMO from rescinding, canceling, or limiting any coverage that has been effective for more than two years. The act permits the commissioner to adopt implementing regulations.

The act exempts the commissioner's decision from the administrative procedure law that permits a person aggrieved by the decision to request a

hearing. Instead, it permits an aggrieved person to file an appeal with Hartford Superior Court within 30 days of when the decision is mailed to the affected parties. The court may grant equitable relief.

The act removes from the preexisting condition definition that applies to individual health insurance policies, excluding short-term policies, a physical or mental condition that manifested itself during the 12 months before coverage became effective. Thus, it defines a preexisting condition as a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 12 months before coverage became effective.

Under prior law, a short-term health insurance policy issued on a nonrenewable basis for six months or less was exempt from preexisting condition coverage requirements if it disclosed in plan materials that preexisting conditions are not covered. The act imposes preexisting condition exclusion limitations on these short-term policies and requires insurers and HMOs to use specific disclosure language.

EFFECTIVE DATE: October 1, 2007

Preferred Provider Network Financial Security

PA 07-191 revises the formula that determines the amount of financial security preferred provider networks (PPNs) and MCOs that contract with PPNs must post, maintain, or arrange for by letter of credit, bond, surety, reinsurance, reserve, or other means. In case of insolvency or nonpayment, the PPN, or another entity the insurance commissioner designates, must use the security to pay the network's health care providers.

Under prior law, the security amount required was the greater of (1) an amount calculated based on the two quarters in the past year in which the largest amounts were owed to network providers, (2) the actual outstanding debt owed them, or (3) another amount the commissioner determined. The act changes the formula's first prong to an amount sufficient for the PPN to pay the providers for two months based on the two months in the past year in which the PPN owed the largest amount to them. It leaves the two other prongs unchanged.

EFFECTIVE DATE: July 1, 2007

Provider Listing

PA 07-18 specifies that the list of health care providers participating in a managed care organizations' (MCO) network, which the MCO must annually provide to plan enrollees, must be provided in writing or through the Internet at the enrollee's option.

The act limits the requirement that an MCO notify an enrollee as soon as possible when his or her primary care physician leaves the MCO's provider network to managed care plans that require an enrollee to select a primary care physician.

EFFECTIVE DATE: October 1, 2007

Special Health Care Plans

PA 07-185 (§§ 18-20) removes a provision that prohibits the sale of special health care plans to small employers after January 1, 1995, permitting such plans to be sold again.

By law, each small-employer insurer must offer small employers a special health care plan, except it can instead refer a small employer with 10 or fewer employees, most of whom are low-income, to the Health Reinsurance Association. The act raises the income eligibility limit for a low-income individual or employee from 200% to 300% of the federal poverty level (FPL).

EFFECTIVE DATE: July 1, 2007

Students to Report Insurance Status

PA 07-2, JSS (§ 24), requires local or regional school boards to require students in their jurisdiction to report whether they have health insurance. The social services commissioner, or his designee, must provide information to the boards on state-sponsored health insurance programs for children, including application assistance. The boards must provide this information, and application assistance, to the student's parent or guardian.

EFFECTIVE DATE: July 1, 2007

PROPERTY & CASUALTY INSURANCE

Condominiums

PA 07-68 requires condominium associations governed by the Common Interest Ownership Act to maintain flood insurance if (1) the property is located in a flood hazard area, as defined and determined by the National Flood Insurance Act and (2) the unit owners, by vote, require it. By law, common expenses for these common interest communities include the cost of repairing and replacing any portion of the common interest community that exceeds the insurance proceeds from the insurance the association must provide by law. The act specifies that common expenses also include any excess

resulting from any applicable insurance deductible.

The act imposes similar requirements for condominiums governed by the Condominium Act. For these condominiums, the requirement applies only if the condominium instruments or unit owners' vote requires it. The act imposes this requirement on the association acting through its board of directors, managing agent, or other authorized agent. The act requires, instead of authorizes, them to provide other types of insurance, including workers' compensation, directors' indemnity, and specialized policies covering lands or improvements in which the unit owners' association has or shares ownership or other rights, if the condominium instruments or unit owners' vote requires it.

Under prior law, premiums for insurance that the law requires the condominium associations governed by the Condominium Act to provide had to be treated as common expenses. This act allows the condominium instruments to instead assess the cost of the insurance coverage against the units in proportion to risk.

EFFECTIVE DATE: October 1, 2007

Guaranty Association

PA 07-21 increases the coverage limit for the Connecticut Insurance Guaranty Association from \$300,000 to \$400,000 for claims arising under policies of property and casualty insurers determined insolvent on or after October 1, 2007. By law, the association pays the full amount of workers' compensation claims.

EFFECTIVE DATE: October 1, 2007

Insurance Requirements for Motor Carriers

PA 07-167 (§ 11) expands insurance requirements for certain motor carriers. By law, owners of certain commercial motor vehicles must file evidence with the DMV commissioner every six months that they have the insurance coverage or other security required by law for each vehicle they operate.

The act requires that all for-hire carriers and private carriers of property or passengers, and the owner of any vehicle that transports hazardous material requiring warning placards under federal law show in their semiannual filings with DMV that they maintain the minimum level of financial responsibility the federal regulations specify. This appears to extend the higher federal, rather than state limits, to certain types of carriers (e.g., private carriers with over 10,000 pounds gross weight ratings carrying non-hazardous cargo in

intrastate commerce or passenger carriers engaged in intrastate commerce, which, because they are not currently covered by the federal limits, may not have to show the same levels of financial responsibility as carriers that are explicitly under the federal regulations).

EFFECTIVE DATE: October 1, 2007

Medical Malpractice Claim Reporting

PA 07-25 extends to insurers of any “medical professional,” instead of just insurers of physicians, advanced practice registered nurses, or physician assistants, the requirement to provide to the insurance commissioner a closed claim report. A “closed claim” is one that has been settled, or otherwise disposed of, and for which the insurer has paid all claims. By law, the insurer must submit the report on a form the commissioner prescribes within 10 days after the last day of the calendar quarter in which a claim is closed. The report includes information only about claims settled under Connecticut law.

The act defines “medical professional” as any person licensed or certified to provide health care services to individuals, including chiropractors, clinical dietitians, clinical psychologists, dentists, nurses, occupational speech and physical therapists, optometrists,

pharmacists, physicians, podiatrists, and psychiatric social workers. By law, a closed claim report contains details about the insured and the insurer, the injury or loss, the claims process, and the amount paid on each claim.

EFFECTIVE DATE: October 1, 2007

Older Driver Premium Discount

PA 07-5 decreases, from 62 to 60, the age at which a driver is eligible for an automobile insurance policy premium discount for successfully completing a Department of Motor Vehicles-approved accident prevention course.

By law, the premium discount must be at least 5% and apply for at least 24 months. The driver must complete the course within one year before applying for an initial discount. For any future discount, the driver must complete a course within one year before the current discount expires. The premium discount is effective at the policy’s next renewal.

EFFECTIVE DATE: October 1, 2007

State Marshal Indemnification

PA 07-69 requires the state to indemnify a state marshal for financial loss and expense, including court costs and reasonable attorney’s fees, from any personal or property injury claim that (1) is caused by or

based on the actions of someone lawfully taken into custody under a court order (specifically a *causas*) from the Superior Court's Support Enforcement Services and (2) occurs while the person is in custody and is transported in a private motor vehicle operated by the state marshal.

If the marshal is subject to a judgment because of his or her malicious, wanton, or willful act, the act requires the marshal to reimburse the state for any expenses incurred in defending the state marshal and the state is not liable to the marshal for any financial loss or expenses.

By law, state marshals must carry personal liability insurance for damages caused by the following conduct: negligent acts, errors, or omissions on which the state marshal becomes legally obligated for damages, false arrest, erroneous service of civil papers, false imprisonment, malicious prosecution, libel, slander, defamation, violation of property rights, or assault and battery committed while making or attempting an arrest or against an arrested person. The conduct must occur during the performance of official duties. The insurance must cover at least \$100,000 for damage to one person or his property and \$300,000 for damage to more than one person or more than one person's property.

EFFECTIVE DATE: October 1, 2007

Storm Damage Mitigation

PA 07-77 prohibits an insurer from refusing to issue or renew a homeowners insurance policy solely because a person has not installed permanent storm shutters on his or her home to mitigate loss from hurricanes and severe storms. It requires an insurer to offer an actuarially sound premium discount to homeowners who install permanent storm shutters or impact-resistant glass for loss mitigation purposes.

The act authorizes the insurance commissioner to (1) establish and adopt regulations for a Coastal Market Assistance Program (CMAP) to help coastal-area residents obtain homeowners insurance and (2) require an insurer that does not issue or renew a homeowners policy to tell the homeowner about CMAP in writing.

For its purposes, the act includes certain owners of mobile homes as homeowners.

EFFECTIVE DATE: Upon passage, except for the insurer prohibition and premium discount provisions, which are effective January 1, 2008. (**PA 07-4, JSS**, changes the effective date of the insurer prohibition to July 1, 2007.)

INSURANCE FUND

Appropriation

PA 07-1, JSS (§§ 7 & 17) appropriates the following amounts to the Insurance Fund: \$23,410,652 for FY 08 and \$24,086,076 for FY 09.

EFFECTIVE DATE: July 1, 2007

Funds Carried Forward for a Different Purpose

PA 07-1, JSS (§§ 46(a) – 46(c)) carries forward the following appropriations from prior years to FY 08 and reallocates them from personal services purposes for the following purposes: (1) up to \$225,000 for a new phone system, (2) up to \$125,000 for information technology upgrade, and (3) up to \$50,000 for credit card fees.

EFFECTIVE DATE: July 1, 2007

Revenue Estimate

PA 07-1, JSS (§ 154) adopts the following Insurance Fund revenue estimates: \$23,500,000 for FY 08 and \$ 24,100,000 for FY 09.

EFFECTIVE DATE: July 1, 2007

Salary Adjustment

PA 07-1, JSS (§ 28) authorizes OPM to transfer funds appropriated to the reserve for

salary adjustments to the following agencies for employee accrual costs stemming from the Early Retirement Incentive Program: (1) the departments of Banking, Insurance, and Public Utility Control; (2) the Office of Consumer Counsel; (3) the Soldiers, Sailors, and Marines' Fund; and (4) the Workers' Compensation Commission.

EFFECTIVE DATE: July 1, 2007

MISCELLANEOUS

Electronically Filed Financial Reports

PA 07-225 makes various changes in insurance company financial reporting requirements. Prior law required all insurers, HMOs, and fraternal benefit societies doing business in Connecticut to annually file financial statements by March 1 and audited financial reports by June 1 with the insurance commissioner. The act (1) limits the annual reporting requirements to domestic and foreign companies, (2) requires the financial statements to be complete when filed, and (3) requires the companies to electronically file the statements and reports with the National Association of Insurance Commissioners (NAIC). Domestic companies that file on time with NAIC must still submit paper copies to the commissioner, but foreign companies do not.

By law, the commissioner may require an insurer, HMO, or fraternal benefit society to file quarterly financial statements. Under the act, if the company electronically files the reports with NAIC on time, then it does not have to give the commissioner paper copies.

The law subjects a company that fails to report as required to a \$100 fine for each day a report is late.

EFFECTIVE DATE: October 1, 2007

Employers' Mutual Association Financial Statements

PA 07-27 permits the insurance commissioner to accept from certain "employers' mutual associations" financial statements that use generally accepted accounting procedures (GAAP) if the statement includes a conversion to statutory accounting procedures (SAP). The association must submit the financial statements quarterly and annually.

EFFECTIVE DATE: October 1, 2007

Technical Revisions

PA 07-54 makes technical revisions to the insurance statutes.

EFFECTIVE DATE: Upon passage

TAX CREDITS

Film Industry Tax Credit

PA 07-236 establishes new transferable credits against the corporation and insurance premium taxes for (1) investments in state-certified film and digital media infrastructure projects and (2) digital animation productions. Digital animation production credits are limited to an aggregate of \$15 million per year. The new credits are administered by the Connecticut Commission on Culture and Tourism (CCCT) and are modeled on the existing state tax credit for film and digital media production expenses. The act also makes several changes in the existing film credit, including applying it against the insurance premium tax as well as the corporation tax and changing the types of productions and expenses that are eligible.

For all three credits, the act:

1. allows an eligible entity to apply for and receive credits during production or while building an infrastructure project;
2. allows those who purchase credits from their original recipients to sell them to others in their turn and allows the credits to change hands up to three times;
3. imposes financial penalties for deliberately submitting

- false information to receive credits; and
4. once credit vouchers are issued, limits the state's power to further audit or review the expenses on which they are based and requires any inflated or inaccurate credits to be recovered from their original recipients rather than any transferees.

EFFECTIVE DATE: July 1, 2007 and applicable to income years starting on or after January 1, 2007.

Historic Structure Rehabilitation Tax Credit

PA 07-250 (§§ 19-21) authorizes tax credits against the insurance premium tax for rehabilitating historic property to be used for both residential and commercial purposes.

EFFECTIVE DATE: Upon passage and applicable to income years starting on or after January 1, 2008.

Job Creation Tax Credit

PA 07-250 (§ 18) expands the job creation tax credit to any company that creates at least 10 new full-time jobs in the state and (2) increases the maximum credit from 25% to 60% of the state income tax withheld from the new employees' wages for up to five successive years. The credit applies against the corporation, utility company, and insurance premium taxes. Total

credits for all eligible companies are still limited to \$10 million per year.

EFFECTIVE DATE: July 1, 2007 and applicable to income years starting on or after January 1, 2007.

WORKERS' COMPENSATION INSURANCE

Benefit Discontinuation or Reduction Notice

PA 07-80 extends, from 10 to 15 days, the period during which an employee can request a hearing after receiving a workers' compensation benefit reduction or discontinuation notice.

In addition to the existing notification requirements, the act requires the notice to identify the:

1. employee's attorney or other representative;
2. insurer;
3. injury, its nature, and the date it occurred; and
4. city or town in which the injury occurred.

The notice must also include medical documentation that establishes the basis for discontinuing or reducing benefits and identify the employee's attending physician. (Under prior law, the employer had to state the reason for the benefit reduction or discontinuation, and the attending surgeon had to sign the form and indicate what kind of work the employee could perform.)

In addition, the notice must state that the employee (1) must call the workers' compensation district office handling the claim to request a hearing, (2) must be prepared to provide medical and other documentation to support the claim, and (3) should note the date the notice was received.

The act increases the maximum penalty for an employer's or insurer's undue delay of a compensation payment due to such party's fault or neglect from \$500 to \$1,000.

EFFECTIVE DATE: October 1, 2007

Failure to Obtain Workers' Compensation Insurance

PA 07-89 authorizes the labor commissioner to issue a stop-work order to an employer who:

1. fails to obtain insurance or provide satisfactory proof of self-insurance for the employer's workers' compensation liability or
2. intends to injure, defraud, or deceive the employer's workers' compensation insurer by knowingly (a) misrepresenting an employee as an independent contractor (and thus not required to be covered by workers' compensation insurance) or (b) providing false, incomplete, or misleading information to the insurance company on the number of its employees in

order to pay a lower premium.

The act also subjects an employer who fails to obtain insurance or self-insurance to (1) a class D felony and (2) a civil penalty from the Labor Department of \$300 for each violation.

EFFECTIVE DATE: October 1, 2007

Medical Fee Schedule; Appeals

PA 07-31 requires the Workers' Compensation Commission chairman, by April 1, 2008, to develop, implement, and annually update a new medical practitioners' fee schedule using values from the Medicare resource-based relative value scale (RBRVS). The Medicare RBRVS conversion must be revenue neutral to the workers' compensation system. (The fee schedule is used as a basis for physician and other practitioner fees for services provided under the Workers' Compensation Act.) The chairman must also implement coding guidelines that conform to the federal Centers for Medicare and Medicaid Services' Correct Coding Initiative.

The act also delays the start of the 20-day deadline to appeal a workers' compensation award or order to the Compensation Review Board in situations when a ruling is pending on a subsequently filed motion. Under the act, the 20-day period to file an appeal with the board begins

when a compensation commissioner rules on the motion. Under prior law, the 20-day period began when a commissioner issued an award or order, regardless of any subsequent motions.

EFFECTIVE DATE: October 1, 2007

Survivor Benefits for Police and Firefighters

PA 07-161 requires a municipality that provides survivor pension benefits for paid police and firefighters who die in the line of duty to continue providing the benefits after the surviving spouse remarries. By law, the municipality's survivor benefit and the workers' compensation survivor benefit cannot exceed 100% of the weekly pay that employees in the same position as the deceased employee receive during the compensable period. The act specifies that the combined weekly benefit cannot exceed 100% of the maximum rate for the same position.

Survivor benefits under workers' compensation end when the surviving spouse remarries or the dependent children reach 18.

EFFECTIVE DATE: October 1, 2007

JLK:ro