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Acts Proposed by the Insurance Department

Public Act 05-20 (House Bill 6618)
An Act Concerning Federal Requirements for Medicare Supplement Plans
(Signed by the Governor 05/09/05)

This act revises Medicare supplement policy requirements to reflect federal law changes that take effect January 1, 2006. It prohibits an insurer from considering a person's age, gender, claim history, or medical condition when deciding to accept or reject an application for coverage under a Medicare supplement policy. But, the act permits an insurer to consider a person's claims history and medical condition when deciding to issue plans H, I, and J to an applicant before January 1, 2006.

By eliminating authority for insurers to consider claims history and medical condition when establishing rates for plans H, I, and J, the act requires insurers to community rate all Medicare supplement plans, since plans A through G must already be community rated by law. (Community rating is the process of developing a uniform rate for all enrollees.)

The act permits, instead of requires, the insurance commissioner to adopt regulations governing Medicare supplement plans. It replaces a reference to 10 plans with 12 plans, "A" through "L" to accommodate new plans K and L. The act also makes a minor change regarding loss ratio premium refunds and several technical changes.

The act applies to insurers, HMOs, hospital and medical service corporations, fraternal benefit societies, and other entities that issue Medicare supplement plans.

EFFECTIVE DATE: July 1, 2005

LOSS RATIO PREMIUM REFUND DONATIONS
This act requires that insurers donate all loss ratio premium refunds held in an interest-bearing account by law to the University of Connecticut Health Center, instead of splitting them between the Health Center and Uncas-on-Thames Hospital, which is defunct.

BACKGROUND
Medicare Supplement Policies
A Medicare supplement policy (also referred to as "Medigap") is a health insurance policy that covers some of the health care costs that Medicare does not cover. Currently, there are 10 standard Medicare supplement policies called plans "A" through "J. " Plan A covers only basic benefits. Plans B through J offer additional benefits, with Plan J offering the most. States retain regulatory authority over policies that meet minimum standards set forth in federal law and by the National Association of Insurance Commissioners.

Medicare Modernization Act of 2003
The federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P. L. 108-173) (MMA) establishes Medicare Part D, which provides prescription drug coverage for seniors. As of January 1, 2006, no new Medicare supplement plans will be sold with prescription drug coverage. If a person enrolls in a Medicare supplement policy that currently covers prescription drugs (i. e. , plans H, I, or J) by December 31, 2005, he can keep that policy with the drug coverage if he does not enroll in Medicare's Prescription Drug Benefit (Medicare Part D). If he chooses to enroll in a Medicare prescription drug benefit plan, he can keep the supplement policy but the drug coverage will be removed from it.

MMA also creates two new Medicare supplement plans, K and L, which include reduced first dollar coverage. One will cover 50% of the cost-sharing required under Medicare Parts A and B and limit out-of-pocket expenses to $4,000, subject to an annual inflationary adjustment. The other will cover 75% of the

cost-sharing and limit out-of-pocket expenses to $2,000.

Loss Ratio
Loss ratio is the ratio between insurance losses sustained and premiums earned in a given period. By law, a Medicare supplement premium rate filing must include a guarantee that actual loss ratios will meet or exceed a specified anticipated loss ratio. If the target is not met, an insurer is required to refund premium to Connecticut policyholders as necessary to bring the actual loss ratio up to the guaranteed level. Refunds under two dollars must be aggregated by the insurer and deposited in an interest-bearing account. At each calendar year end, the insurer must donate the account balance as specified by law.

Public Act 05-57 (House Bill 6622)
An Act Concerning Protecting Seniors in Annuity Transactions
(Signed by the Governor 06/02/05)

This act requires the insurance commissioner to adopt regulations to establish (1) standards for selling or exchanging annuities to a senior consumer and (2) procedures for making annuity sales or exchange recommendations to a senior consumer. A "senior consumer" is an individual age 65 or older. In the case of a purchase by more than one person, the purchaser is considered a senior consumer if one of the people is age 65 or older.

By law, “annuities” are agreements to make periodic payments where all or some of the payments depend on a person’s continued life or a specified number of years. It does not include payments under a life insurance policy.

EFFECTIVE DATE: Upon passage

Public Act 05-61 (House Bill 6806)
An Act Concerning Insurance Producer Compensation (*includes Ins. Dept. lang*.)
(Signed by the Governor 06/02/05)

This act expands what constitutes a misrepresentation of an insurance policy. Existing law makes a misrepresentation to induce the lapse, forfeiture, exchange, conversion, or surrender of an insurance policy an unfair and deceptive insurance practice. This act makes a misrepresentation to induce the purchase of insurance an unfair and deceptive insurance practice. It also includes an intentional premium rate misquote as a misrepresentation.

This act prohibits an insurance producer or his affiliate who receives compensation directly from a customer for an insurance sale from also receiving compensation from an insurer or other third party for the sale unless, before he delivers the insurance policy to the customer, the producer (1) obtains the customer’s acknowledgement that he or his affiliate will receive compensation from the insurer or other third party and (2) discloses the compensation amount. If the amount is unknown, he must give a reasonable estimate, if possible, and describe how the compensation is calculated.

The customer’s acknowledgement must be in writing, but if the transaction occurs over the telephone or electronically and written consent cannot reasonably be obtained, the producer can document the acknowledgement himself.

The act does not apply to a producer (1) whose only compensation is from an insurer (e. g. , he is the insurer’s employee) or (2) who does not receive compensation from the customer and informs the customer before policy delivery that (a) he will receive compensation from the insurer or (b) he represents the insurer and can service the customer on the insurer’s behalf. It also does not apply to (1) the placement of insurance in surplus lines or residual markets, (2) a person who is a licensed producer but only acts as an intermediary between the insurer and the customer’s producer, or (3) a reinsurance intermediary.

Compensation from a customer excludes commissions that are deductible from the customer's premium payment and fees agreed to in writing for certain administrative services authorized by current regulation. Compensation from the insurer means payments, commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or other valuable consideration, whether agreed to in writing or not.

EFFECTIVE DATE: October 1, 2005

BACKGROUND

Unfair and Deceptive Insurance Practice
When the insurance commissioner determines, after a hearing, that a person has committed an unfair and deceptive insurance practice, she may order fines, restitution, license suspension or revocation, or any combination of these. Fines are up to $1,000 per violation, not to exceed $10,000 in total. If the person knowingly commits the violation, fines are up to $5,000 per violation, not to exceed $50,000 in total in any six-month period.

Public Act 05-94 (Senate Bill 1002)
An Act Concerning Appeals of Health Insurance Determinations made to the Insurance Commissioner
(Signed by the Governor 06/07/05)

This act requires a health insurer to (1) have a grievance process for enrollees to appeal the insurer's actions or inactions and (2) notify enrollees of the process at enrollment annually and when it denies a service, admission, or hospital stay extension. It also expands the external appeal law to permit a plan enrollee to appeal a health insurer's denial to the insurance commissioner after exhausting the insurer's process. By law, an enrollee can appeal a managed care organization or utilization review company decision to the commissioner.

The act requires utilization review company that, after an appeal, upholds a decision to not authorize an admission, service, procedure, or hospital stay extension to provide in writing to the individual (1) the main reason for the decision, (2) notice that he has exhausted all internal appeal opportunities, and (3) an external appeal application and procedures.

The act requires each managed care organization (MCO) and health insurer that, after appeal, upholds a claim denial based on medical necessity to provide the enrollee in writing (1) notice that he exhausted all internal appeal opportunities and (2) an external appeal application and procedures.

By law, an MCO must provide the commissioner, enrollee, or provider certain information regarding a plan under which an appeal is made within five business days of receiving a written request. The act eliminates all of the information that must be sent if the appeal relates to a self-insured governmental health plan, except for verification that it is self-insured.

EFFECTIVE DATE: July 1, 2005

Public Act 05-140 (Senate Bill 999)
An Act Concerning Changes to the Insurance Statutes
(Signed by the Governor 06/24/05)

This act makes several changes to Connecticut's insurance statutes.

The act removes from the list of unfair and deceptive insurance practices nonpayment of mandatory fees to

the insurance commissioner. This means that a person's or insurance company's failure to pay any of the required fees will no longer be subject to the unfair practice penalties, which include fines and license suspension or revocation. The act does not affect any other penalty allowed by law for not paying fees or paying them late.

The act eliminates the requirement that an insurer provide people covered under an automobile insurance policy written notice of the availability of full glass repair or replacement coverage. By law, each automobile insurance policy must include such coverage at the insured's request.

The act also makes changes in the Connecticut Insurance Guaranty Association statutes. The act specifies that the association is not responsible for a claim that arises out of a policy issued by an insurer that was not licensed to transact insurance in Connecticut either when the policy was issued or when the insured event occurred.

It also redefines "insolvent insurer" for purposes of the guaranty association. Under prior law, an insolvent insurer included the legal successor of the insolvent insurer in the event of a merger. Under the act, an insolvent insurer instead includes the legal successor of an insurer (because of a merger) that was licensed to transact insurance in Connecticut either when the policy was issued or when the insured event occurred, as long as an insurance regulator with jurisdiction approved the merger. By law, a court of competent jurisdiction must make the determination that the insurer is insolvent.

The act also broadens the definition of an "insolvent insurer" to include an insurer (1) that inherits the policy obligations of an insurer (because of a corporate division) licensed to transact insurance in Connecticut when the policy was issued or when the insured event occurred, if the corporate division is approved and (2) determined to be insolvent by a court of competent jurisdiction. The corporate division must be approved in a jurisdiction that allows it by an insurance regulator having jurisdiction over it.

EFFECTIVE DATE: October 1, 2005, except for the changes to the guaranty association statutes, which are effective upon passage and applicable to insolvencies occurring on or after that date.

BACKGROUND

Connecticut Insurance Guaranty Association

Connecticut has a property and casualty insurance guaranty association fund. All insurance companies licensed to issue property and casualty coverage—with the exceptions prescribed by law— must belong to the association.

If an insurance company defaults, the guaranty association pays valid claims of policyholders and other claimants, up to the dollar limits of the policy subject to ceilings fixed by state law. Policyholders also may receive partial refunds of premiums.

Payment of claims by the guaranty association is coordinated with the Connecticut Insurance Department. Guaranty association payments are triggered by an order of the insurance commissioner or a court of competent jurisdiction declaring a life or health insurance company to be "impaired" or by an order of a court of competent jurisdiction declaring a property and casualty company to be insolvent.

Public Act 05-237 (House Bill 6619)
An Act Concerning Discount Health Plans
(Signed by the Governor 07/11/05)

This act establishes a regulatory framework for medical discount plans and organizations that offer such plans. It establishes requirements for (1) incorporation and licensure, (2) net worth, (3) provider agreements, (4) advertising and plan material content, and (5) consumer disclosures. It also establishes fines and penalties for violations and authorizes the commissioner to adopt implementing regulations.

EFFECTIVE DATE: January 1, 2006, except for the prohibition on marketing, advertising, or selling plans that do not meet the mandatory plan provisions and related fines, which are effective July 1, 2005.

Public Act 05-266 (House Bill 6805)
An Act Concerning the Renewal of Insurance Producer Licenses
(Signed by the Governor 07/13/05)

This act (1) makes an insurance producer license renewable every two years on the licensee's birthday instead of on February 1 in even-numbered years; (2) permits the insurance commissioner to establish a process to transition producers to the new license renewal schedule and establishes a $ 40 transitional license fee; (3) increases license renewal fees to $ 40 per year or any portion thereof instead of $ 40 every two years; (4) requires the commissioner to notify a producer at least 30 days before his license expires; (5) adds license renewal fee payment to the renewal requirements; (6) authorizes the commissioner to implement a more efficient license renewal process that supercedes the mandated requirements upon implementation; and (7) permits the commissioner to adopt regulations to establish a license renewal schedule.

EFFECTIVE DATE: October 1, 2005, except for the license renewal fee change, which is effective January 1, 2006.

Other Acts of Interest

Public Act 05-10 (Senate Bill 963)
An Act Concerning Civil Unions
(Signed by the Governor 04/20/05)

This act authorizes same sex couples to enter into civil unions, granting them the same legal benefits, protections, and responsibilities as married couples. It incorporates civil unions by reference in most statutes that use or define terms indicating a spousal relationship. It establishes eligibility, application, and licensing criteria; specifies who can perform civil union ceremonies; and sets forth record-keeping requirements. The act (1) restricts civil unions to couples over age 18, (2) exempts people authorized to perform civil union ceremonies from liability for failing or refusing to do so, and (3) requires town clerks to give civil union license applicants copies of the relevant laws. Otherwise, the act's substantive provisions and penalties are identical to current marriage statutes.

The act also defines "marriage" as the union of one man and one woman. It establishes circumstances under which the state will recognize civil unions performed in other countries.

EFFECTIVE DATE: October 1, 2005

BENEFITS, PROTECTIONS, AND RESPONSIBILITIES
The act specifies that the rights it extends to civil union partners may derive under statute, administrative regulations or court rules, policy, common law, or any other source of civil law. Generally, these fall into the following categories:
1. family law, including marriage, divorce, and support;
2. title, tenure, descent and distribution, intestate succession, wills, survivorships, or other incidents of the acquisition, ownership, or transfer (during life or at death) of real or personal property;
3. state and municipal taxation;
4. probate courts and procedure;
5. pensions and group insurance for employees in plans not regulated exclusively by federal law;
6. family leave benefits;
7. financial disclosure and conflict-of-interest rules;
8. protection against discrimination based on marital status;

9. emergency and non-emergency medical care and treatment, hospital visitation and notification, and authority to act in matters affecting family members;
10. state public assistance benefits;
11. workers' compensation;
12. crime victims' rights;
13. marital privileges in court proceedings; and
14. vital records and absentee voting procedures.

Excluded Laws
The act does not incorporate civil unions by reference in the chapter of the General Statutes relating to marriage procedures and formalities. But it includes new provisions setting out the same procedures and formalities for applicants and parties to civil unions.
Civil unions are also specifically excluded under the act from the statute that states that "the current public policy of the state is now limited to a marriage between a man and a woman" (CGS § 45a-727a(4)).

ELIGIBILITY CRITERIA
To be eligible to form a civil union, the act requires that each party be of the same sex, not a party to another civil union or a marriage, and no more closely related to one another than first cousin. Unions between people more closely related are void.

People under age 18 can enter into civil unions only if a court has declared them emancipated (legal adults). By law, partners 16 or 17 years of age may marry if their parents consent, and those under age 15 may do so with a probate judge's consent. Under the act, as well as existing marriage law, people under conservatorships must obtain their conservator's written permission. A conservator's refusal to permit the ceremony to proceed must be based on clear and convincing proof of recent behavior that would cause or create a risk of harm.

Public Act 05-15 (House Bill 6868)
An Act Concerning Filing Deadlines for Managed Care Ombudsman Report
(Signed by the Governor 05/09/05)

This act requires the managed care ombudsman to file his annual report by March 1 instead of January 1. It also requires the Office of Managed Care Ombudsman's advisory committee to file its annual evaluation of the office by April 1 instead of February 1. Reports are filed with the governor and the General Assembly's Public Health and Insurance and Real Estate committees.

EFFECTIVE DATE: October 1, 2005

Public Act 05-25 (House Bill 6807)
An Act Concerning Fees for Requests for Agent Appointments
(Signed by the Governor 05/09/05)

This act exempts a non-Connecticut domiciled (non-domestic) insurance company from the $ 25 per "request for agent appointment" filing fee if the state or country where the company is domiciled does not require a fee when a Connecticut insurance company requests an agent appointment in that state or country.

EFFECTIVE DATE: October 1, 2005

BACKGROUND
Agent Appointments and Fees

Before a licensed insurance producer may act as an agent on behalf of a Connecticut insurance company, (1) the company must request an agent appointment from the Insurance Department and (2) the department

must issue the appointment. In addition to the request for agent appointment fee, state law requires (1) a $40 fee per appointment issued or continued for an agent of a domestic insurance company and (2) a $20 fee per appointment issued or continued for an agent of a non-domestic insurance company. The latter fee is waived if the other state or country does not require a fee for an appointment issued to an agent of a Connecticut insurance company.

Public Act 05-29 (House Bill 6863)
An Act Concerning Minor and Technical Changes to the Insurance Statutes
(Signed by the Governor 05/09/05)

This act expands the type of information a managed care organization (MCO) must provide when responding to the insurance commissioner's, an enrollee's, or a provider's request for information about an enrollee's appeal under a self-insured government health care contract. By law, an MCO must provide instructions on how to access an electronically available fully insured policy under which an appeal is brought. The act requires an MCO to send similar instructions on how to access an electronically available self-insured government contract under which an appeal is brought. Information must be provided within five days of the request. (PA 05-94 amends this act by eliminating the requirement that an MCO provide any information related to a self-insured government health care contract, except verification of its self-insured status.)

The act also makes technical and conforming changes in the insurance statutes.

EFFECTIVE DATE: October 1, 2005

PA 05-63 (House Bill 6866)
An Act Concerning Life Insurance Offered to State Employees
(Signed by the Governor 06/02/05)

This act makes a state employee or legislator ineligible for a state-issued group life insurance policy as both a retiree and an active employee or legislator. The act permits him to keep any policy obtained through the state in accordance with the policy terms if the policy was in effect on June 30, 2005. Thus, for example, if a person retires from state service, maintains a life insurance policy that took effect before July 1, 2005, and is later rehired as an active employee, he is not eligible for another policy but can keep his existing one.

By law the comptroller, with the attorney general's and insurance commissioner's approval, can revise the group life insurance plan for state employees. Employees are eligible for coverage after six months of continuous service. Legislators are eligible six months after taking office.

EFFECTIVE DATE: July 1, 2005

Public Act 05-65 (House Bill 6917)
An Act Concerning Interlocal Risk Management Agencies
(Signed by the Governor 06/02/05)

Connecticut law permits two or more municipalities to form an interlocal risk management agency to pool risks and jointly purchase insurance for (1) public liability, automobile, and property; (2) workers' compensation, and (3) excess risk. Prior law required each pool to maintain a contingency fund of a specified amount. This act allows an interlocal risk management pool organized between July 1, 1995 and July 1, 2005 that established a contingency fund as required before July 1, 2005 to forgo the contingency requirements until July 1, 2010.

Beginning July 1, 2010, the act requires a workers' compensation or excess risk pool that chose not to

maintain a contingency fund to maintain at least $100,000 for contingencies for each fiscal year it operates, but the pool does not have to have more than $500,000 total.

Beginning July 1, 2010, the act requires a public liability, automobile, and property risk pool that opted not to maintain a contingency fund to maintain one at a minimum of: (1) as of June 30, 2011, $100,000 plus 1% of total member contributions for the preceding year; (2) as of June 30, 2012, $200,000 plus 2% of total member contributions for the preceding year; (3) as of June 30, 2013, $300,000 plus 3% of total member contributions for the preceding year; (4) as of June 30, 2014, $400,000 plus 4% of total member contributions for the preceding year; and (5) as of June 30, 2015, $500,000 plus 5% of total member contributions for the preceding year.

As of July 1, 2015, the act reinstates prior law for all pools. Thus, a workers' compensation or excess risk pool must maintain at least $100,000 for contingencies for each fiscal year it operates, but the pool does not need to have more than $500,000 total. A public liability, automobile, and property risk pool must maintain at least $500,000 for contingencies for its first fiscal year of operation and increase it by 5% of total member contributions for each subsequent year until the contributions-to-fund ratio is no more than three to one.

The act also requires each pool operating under the requirements of this act to submit reports to the insurance commissioner, as she requires.

EFFECTIVE DATE: July 1, 2005

BACKGROUND
Contingency Fund
A contingency fund is unassigned money held above and beyond other pool liability reserves. Members advance the funds to the pool. An advance is repaid only when a repayment does not reduce the fund below its required minimum.

Public Act 05-69 (Senate Bill 30)
An Act Concerning Health Insurance Coverage for Breast Cancer Screening
(Signed by the Governor 06/02/05)

This act requires certain health insurance policies to cover physician-recommended comprehensive ultrasound screening of an entire breast or breasts for a woman classified as a category 2, 3, 4, or 5 on the American College of Radiology's Breast Imaging Reporting and Database System (BI-RADS), subject to any policy provisions applicable to other covered services.

The act applies to individual and group health insurance policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including those provided by HMOs. The act also applies to individual policies that cover (1) accidents only and (2) limited benefits.

EFFECTIVE DATE: October 1, 2005

BACKGROUND
Ultrasound
A breast ultrasound sends high-frequency sound waves through the breast. A computer detects the sound wave echoes to create an image that is displayed on a viewing screen.

BI-RADS Categories
The American College of Radiology collaborated with the National Cancer Institute, the Center for Disease Control and Prevention, the American Medical Association, and others to develop BI-RADS. BI-RADS is a breast mammogram assessment tool. There are six BI-RADS categories, 0 through 5, each with a specific finding and recommendation, as shown below. The radiologist includes a BI-RADS category in the

mammogram report he prepares for the referring doctor.

Public Act 05-97 (Senate Bill 1297)
An Act Concerning Managed Care Grievance Procedures
(Signed by the Governor 06/07/05)

By law, a managed care organization (MCO) must maintain a specified grievance process for enrollees to appeal the MCO's actions or inactions. This act makes violating the grievance requirements an unfair and deceptive insurance practice, subject to a fine up to $1,000 for each violation, to a maximum of $10,000. If a person knew or should have known his action was a violation, the penalty is (1) a fine up to $5,000 for each violation, to a maximum of $50,000 in any six-month period; (2) license suspension or revocation; and (3) restitution of any amounts obtained through the violation.

By law, a grievance must be resolved within 60 days after it is initiated, unless the enrollee requests an extension. The act permits a person acting on the enrollee's behalf also to request an extension. It requires an MCO to pay a $25 fine for each time it does not provide notice of the grievance resolution within the required timeframe. The fines are payable to the insurance commissioner for deposit into the Insurance Fund and must be allocated to the managed care ombudsman's office (which PA 05-102 renames the Office of the Healthcare Advocate).

The act requires the MCO to notify the enrollee and his provider of the grievance process when it denies a service, admission, or stay extension the provider ordered. Prior law required it to notify just the enrollee of the grievance process when it denied any service, admission, or stay extension, regardless of who requested it. The notice must explain (1) the process for submitting a grievance; (2) that the enrollee or a person acting on his behalf, including his provider, can submit a grievance; and (3) the insurer's timeframe to resolve a grievance. A grievance can be submitted orally, electronically, or in writing.

EFFECTIVE DATE: October 1, 2005

BACKGROUND
Related Act
PA 05-94 extends the grievance procedure requirements to health insurers, requires a final denial notice to include instructions on how to appeal to the insurance commissioner, and limits the information an MCO must provide about a self-insured government plan that is the subject of an appeal.

Public Act 05-100 (Senate Bill 1351)
An Act Concerning Retaliatory Laws Against Connecticut Domiciled Insurers
(Signed by the Governor 06/07/05)

When another state or foreign country imposes taxes; fees; fines; deposit requirements; or other obligations, restrictions, or prohibitions against Connecticut insurance companies doing business there that exceed those Connecticut imposes on their insurance companies operating here, Connecticut law imposes an equivalent retaliatory charge or restriction on the other jurisdiction's companies doing business in Connecticut.

This act invokes Connecticut's retaliatory law when another jurisdiction retaliates against Connecticut insurers because Connecticut imposes certain types of taxes, fees, or charges on that jurisdiction's insurers. These taxes, fees, or charges include real and personal property taxes based on property value; personal income taxes; premium taxes on special health care plans for previously uninsured small employers; agents' license fees; and special purpose assessments, including assessments for workers' compensation and the Insurance Guaranty Association Fund.

EFFECTIVE DATE: October 1, 2005

Public Act 05-102 (Senate Bill 1205)
An Act Concerning Appeals of Denials or Determinations by Managed Care Organization and Renaming the Office of the Managed Care Ombudsman
(Signed by the Governor 06/07/05)
The law allows an enrollee, or health care provider acting on an enrollee's behalf with his consent, who has exhausted the internal mechanisms provided by a managed care organization (MCO) or utilization review (UR) company, to appeal a claim denial based on medical necessity to the insurance commissioner up to 30 days after receiving written notice of the denial. It also allows appeals of determinations not to certify an admission, service, procedure, or extension of stay.

The act allows the insurance commissioner to issue an order specifying how an MCO or UR company must make determinations about procedural or diagnostic coding if she receives three or more appeals of denials or determinations by the same MCO or UR company about the same procedural or diagnostic coding. The commissioner can issue the order on her own motion.

The act also changes the name of the Office of Managed Care Ombudsman to the Office of Healthcare Advocate and makes a number of technical changes to accomplish this throughout the statutes. The duties and responsibilities of the office remain the same.

EFFECTIVE DATE: October 1, 2005

Public Act 05-103 (Senate Bill 1299)
An Act Concerning Extended Reporting Period Coverage under Medical Malpractice Insurance Policies
(Signed by the Governor 06/07/05)

This act requires that under certain circumstances, professional liability insurance policies issued on a claims-made basis provide coverage for prior acts and unlimited extended reporting period coverage without additional charge to insureds. The requirement applies if, while an insured is covered under the policy, (1) the insurer stops offering the policy in Connecticut for any reason and the insured is over the age of 55 and has been insured by the insurer for the seven consecutive years immediately preceding the discontinuance or (2) the insured dies, becomes permanently disabled and unable to carry out his or her practice, or retires permanently from practice. (The act overrides current regulations relating to physicians, advanced practice registered nurses, or physician assistants who retire—(see BACKGROUND-Related Regulation).

The act applies to policies delivered, issued for delivery, or renewed in Connecticut on or after October 1, 2005, to a physician or surgeon, advanced practice registered nurse, physician assistant or hospital.

The act makes prior acts coverage and unlimited extended reporting period coverage enforceable against an insurer that stops offering such policies in Connecticut for any reason before the insured's death, disability, or retirement, if the insured is covered under the policy on the date the insurer stops offering the policy. The act requires the insurer to provide such coverage upon death, disability, or retirement in the same manner as if the insurer continued offering it in Connecticut.

EFFECTIVE DATE: October 1, 2005

BACKGROUND
Claims Made Policy
By law, "claims-made policy" means an insurance policy or an endorsement to an insurance policy that covers liability for injury or damage that the insured is legally obligated to pay (including injury or damage occurring before the effective date of the policy, but after the retroactive date, if any), arising out of incidents, acts, or omissions, as long as the claim is first made during the policy period or any extended reporting period (Conn. Agencies Reg. § 38a-327-1). (It is not clear if this definition will apply to the act.)

Related Laws
The law requires that every professional liability insurance policy issued on a claims-made basis contain (1) a provision for the purchase of coverage for prior acts and (2) a contractual right of the insured to purchase at any time during the policy period (or within 30 days after it) equivalent coverage for all claims occurring during an insured policy period regardless of when made (CGS § 38a-394).

Anyone required by law to have a medical malpractice insurance policy who has a claims-made policy may not lose the right to unlimited additional extended reporting period coverage after he permanently retires from practice because he provides free professional services at a tax-exempt clinic (CGS § 20-11b).

Related Regulation
Under an Insurance Department regulation, which applies to all claims-made policies for professional liability, unlimited additional extended reporting period coverage must be provided without additional cost to the insured if, while covered by a claims-made professional liability policy, the insured dies or becomes permanently disabled and unable to carry out his practice. It also applies if the insured retires permanently from practice:
1. at or over age 65 having been insured with the same insurer on a claims-made basis for at least the five consecutive years immediately preceding retirement, or
2. at or over age 62 having and has been insured with the same insurer on a claims-made basis for at least the 10 consecutive years immediately preceding retirement (Conn. Agencies Reg. § 38a-327-3(e)).

Regarding professional liability insurance, "additional extended reporting period coverage" means coverage for the period specified in the policy during which claims first made after termination of coverage, for injury or damage that occurs on or after the retroactive date, if any, but before the policy term expires is considered made during the policy term (Conn. Agencies Reg. § 38a-327-1(f)(2)).

If a policy has no aggregate liability limit, the insurer must offer additional extended reporting period coverage without an aggregate liability limit. If a policy contains an aggregate liability limit, the insurer must offer additional extended reporting period coverage with a limit at least equal to that specified in the policy (Conn. Agencies Reg. § 38a-327-3(f)).

Public Act 05-162 (Senate Bill 31)
An Act Concerning Notice of Late Fees under Personal Risk Insurance Policies and the Commissioners' 2001 Standard Ordinary Mortality Table
(Signed by the Governor 07/01/05)

This act requires personal risk insurers that charge a fee when an insured pays his premiums late to conspicuously display the fee amount and applicability on the bill sent to the policyholder.

By law, "personal risk insurance" includes homeowners, tenants, private passenger automobile, mobile home, and other property and casualty insurance for personal, family, or household needs, but excludes workers' compensation.

The act also revises the law that regulates the calculation of life insurance minimum reserves, nonforfeiture benefits, and premiums by allowing an insurer to use the 2001 Commissioners' Standard Ordinary (CSO) Mortality Table, instead of older versions, for policies issued after December 31, 2003. For policies issued before April 1, 2005, the act prohibits insurers from using the 2001 table to increase an insured's already agreed-upon premiums. (Apparently an insurer can use the 2001 table to effect a premium reduction for policies issued before April 1, 2005.) An insurer must give the insurance commissioner written notice of its decision to use the 2001 table before January 1, 2009. Beginning on January 1, 2009, the act requires insurers to use the 2001 table.

EFFECTIVE DATE: January 1, 2006, except for the provisions regarding life insurance mortality tables, which are effective upon passage.

BACKGROUND

Reserve Valuation

By law, insurers must apply a standard accounting methodology to calculate the value of its future policy obligations. This valuation is the basis for setting minimum reserves (i. e. , the amount of money an insurer must have on hand to pay claims and other obligations). The calculation includes certain interest rates and the use of mortality tables.

In general, as life expectancy increases, a smaller reserve amount is needed because the expected future earned interest increases. Thus, if the 2001 table reflects longer life spans than the older tables currently in use and an insurer calculates reserves based upon it, the insurer may need to keep less in reserve.

Nonforfeiture Benefits

By law, a life insurance policy guarantees a certain minimum benefit (either a lump sum cash payment or the paid-up insurance amount) to a policyholder who stops paying his premiums. Nonforfeiture benefit calculations also use interest rates and mortality tables. Increased life expectancy may result in lower premiums since an insurer will have longer to invest premiums collected before having to pay out on the policy.

2001 CSO Mortality Table

The "2001 CSO Mortality Table" is a table of mortality rates for women and men. The American Academy of Actuaries CSO Task Force developed the 2001 table based on the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force's Valuation Basic Mortality Table. The National Association of Insurance Commissioners adopted the 2001 table in December 2002.

Retroactive Application of a Law

The act permits an insurer, after December 1, 2004 and at its election, to use the 2001 mortality table for any one or more life insurance policies issued after December 31, 2003 and before April 1, 2005 for reserve and nonforfeiture valuations, except to increase premiums. It permits an insurer to use the 2001 table after December 31, 2004 for policies issued on and after April 1, 2005 for valuation, including to increase premiums. This constitutes a retroactive application of the new provisions.

General statutory construction applies new laws prospectively and considers retroactive application as unfair (Sutherland Statutory Construction). Despite this default rule, courts have upheld retroactive legislation that is determined to be reasonable. Courts weigh retroactivity carefully, looking at (1) the nature and identity of the parties; (2) their rights and reliance on the existing law; (3) the impact on completed transactions; and (4) constitutional concerns, such as due process.

Public Act 05-193 (Senate Bill 1251)

An Act Concerning Owner-controlled Insurance Programs on State and Municipal Construction Projects

(Signed by the Governor 07/01/05)

This act prohibits contracts to build, alter, or repair public buildings or works from allowing or requiring the state or a municipality to maintain an owner-controlled insurance program ("OCIP"), with two exceptions: (1) any "UConn 2000" infrastructure improvement project or (2) municipal projects totaling at least $100 million that are under the supervision of one construction manager or located within a municipality's boundaries if under the supervision of two or more construction managers.

The act requires each principal or contractor to disclose in its project plans or specifications when soliciting bids that the project will be covered by an OCIP. It also establishes certain requirements for an OCIP contract or insurance policy, which must provide that:

1. coverage for work performed and materials furnished continue from the date work is completed to the date all causes of action are barred under any applicable statute of limitations;
2. the principal and all covered contractors receive notice of a change in coverage, coverage cancellation, or a refusal to renew coverage;

3. the effective date of a change in coverage is at least 30 days after the principal and contractors receive notice of it; and
4. the effective date of a cancellation or non-renewal of coverage is at least 60 days after the principal and contractors receive notice of it.

Under the act, an OCIP is an insurance procurement program where a principal provides and consolidates insurance coverage for one or more contractors or one or more construction projects.

The act also limits the bonding requirement for contracts exceeding $50,000 to the state and municipalities, instead of the state and any of its political subdivisions.

EFFECTIVE DATE: Upon passage

BACKGROUND
Owner-Controlled Insurance Program (OCIP)
In an OCIP, the construction project owner purchases insurance for other participants in the project and administers the project's loss-prevention program. The coverage can include general liability, builder's risk, workers' compensation, design errors and omissions, excess, umbrella, and other special coverage. The owner requires the other project participants to reduce their bid prices by eliminating their usual insurance costs in exchange for the owner-provided coverage. An OCIP administrator runs the program, acts as the owner's agent, and is usually selected by the insurance broker. When an owner implements an OCIP, the contractor and subcontractors must participate.

Public Act 05-196 (Senate Bill 508)
An Act Concerning Health Insurance Coverage for Infertility Treatment
(Signed by the Governor 07/01/05)

This act requires individual and group health insurance policies to cover the medically necessary costs of diagnosing and treating infertility. It specifies permissible coverage limitations and requirements. It also permits religious employers and individuals to exclude infertility coverage if it is contrary to their religious tenets. Prior law required insurers and HMOs to offer infertility coverage to group plan sponsors, who could have rejected or accepted it.

The act requires a clinical practice that performs insurance-covered in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), or zygote intra-fallopian transfer (ZIFT) procedures to report certain information to the Department of Public Health (DPH) by February 1 following any year it performs the procedures.

The act applies to policies delivered, issued, amended, renewed, or continued on and after October 1, 2005 that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including HMOs.

EFFECTIVE DATE: October 1, 2005

INFERTILITY COVERAGE
The act requires health insurance policies to cover medically necessary expenses incurred for the diagnosis and treatment of infertility, including ovulation induction, intrauterine insemination, IVF, uterine embryo lavage, embryo transfer, GIFT, ZIFT, and low tubal ovum transfer. It defines "infertility" as the inability of a presumably healthy person to conceive or produce conception or sustain a successful pregnancy during a one-year period.

COVERAGE LIMITATIONS AND REQUIREMENTS
A policy can:
1. limit coverage to people under age 40;
2. place a lifetime ovulation induction coverage limit of four cycles;

3. place a lifetime intrauterine insemination coverage limit of three cycles;
4. place a lifetime IVF, GIFT, ZIFT, or low tubal ovum transfer limit of two cycles and two embryo implantations per cycle, where each fertilization and transfer procedure counts toward the maximum as one cycle;
5. require covered services to be performed at facilities conforming to standards and guidelines developed by the American Society for Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility;
6. limit coverage to people who have been covered by the policy for at least 12 months;
7. require a person seeking infertility coverage to disclose to the insurer on a form developed by the insurance commissioner any previous infertility treatment or procedures for which a different health insurance policy provided coverage; and
8. limit IVF, GIFT, ZIFT, and low tubal ovum transfers to people who have used less expensive and medically viable treatments or procedures covered under the policy but remain infertile.

But, coverage for IVF, GIFT, ZIFT, and low tubal ovum transfers cannot be denied if a person forgoes a less expensive treatment option because her doctor determines it is unlikely to be successful.

RELIGIOUS EXEMPTION
An insurer, medical or service corporation, or HMO can issue a religious employer a health insurance policy that excludes infertility diagnosis and treatment coverage contrary to the employer's bona fide religious tenets.

If a person states in writing that infertility diagnosis and treatment is contrary to his religious or moral beliefs, an insurer, medical or service corporation, or HMO can issue him a policy or rider that excludes the coverage.

An entity that issues a policy excluding the infertility coverage because of the religious exemption must give written notice of the exclusion to each insured or prospective insured. The notice must appear in the policy, application, and sales brochure and be in at least 10-point type.

Under the act, a "religious employer" is a "qualified church-controlled organization," as defined in federal law, or a church-affiliated organization. Federal law defines "qualified church-controlled organization" as a church-controlled tax-exempt organization, other than one that (1) offers goods, services, or facilities for sale to the general public, other than those sold at a nominal charge that is substantially less than the actual cost, and (2) normally receives more than 25% of its support from either (a) government sources or (b) receipts from admissions, merchandise sales, services performed, or facilities furnished (26 USC § 3121).

REPORTABLE INFORMATION
A clinical practice that performs insurance-covered IVF, GIFT, and ZIFT procedures must report to DPH by February 1 the (1) number of procedures performed the previous year; (2) number of multiple births or conceptions per pregnancy with a breakdown of births or conceptions per pregnancy; and (3) rates of complications. It must also report, per patient on average and by the number of attempts required, the (1) number of procedures attempted before a successful implantation, (2) number of embryos implanted, and (3) pregnancy rate. The practice must report the information on a form DPH develops.

BACKGROUND
Infertility Procedures
Ovulation induction uses medication to stimulate development of one or more mature follicles (where eggs develop) in a woman's ovaries. IVF uses a drug to stimulate a woman's egg production. Once mature, the eggs are removed to a culture dish and fertilized with sperm. After fertilization, embryos are placed in the woman's uterus.
In GIFT, egg and sperm are placed in a woman's fallopian tubes where fertilization can occur naturally. ZIFT involves placing embryos in a woman's fallopian tubes. Low tubal ovum transfer involves transferring eggs past a blocked or damaged section of the fallopian tube to an area closer to the uterus. Uterine embryo lavage is a procedure by which the uterus is flushed to recover a preimplantation embryo from a donor and then transferring it to the woman who is to bear the child.

Public Act 05-199 (Senate Bill 1336)
An Act Concerning Revision to Statutes Governing the Second Injury Fund
(Signed by the Governor 07/01/05)

This act makes changes in the laws governing the Second Injury Fund, a state-run workers' compensation fund that the state treasurer administers. It exempts the fund from liability in certain cases and reduces the fund's potential liability by prohibiting retroactive claims older than two years from the date on which the employer or its insurer paid benefits.

It changes the method of assessing employers for fund liabilities and authorizes:
1. the treasurer to audit employers and insurers regarding requested information and any fund payment due,
2. penalties of 15% for insurers and employers who fail to pay their fund assessment or surcharge and 6% annual interest on unpaid assessments and surcharges, and
3. workers' compensation commissioners and the treasurer to enter into settlements with claimants either before or after an award against an employer.

The act defines employer paid losses and prohibits credits against paid losses with some exceptions.
For insured employers, the act imposes collection and payment responsibilities on their insurance carriers.

EFFECTIVE DATE: July 1, 2006

PROVISIONS REDUCING LIABILITY
The act reduces the fund's liability by (1) exempting the fund from being considered an employer or insurer when liability is given to an employee's previous employers, (2) prohibiting claims on the fund older than two years from the date on which the employer or its insurer paid benefits, (3) exempting it from claims brought due to an insolvent insurer, and (4) exempting it from claims by the Insurance Guarantee Association.

Reimbursement in Previous Employer Claims (§ 1)
By law, a person's last employer is initially responsible for his workers' compensation claim. But a workers' compensation commissioner can order an earlier employer or his insurer to reimburse the last employer or his insurer, if the commissioner determines that the earlier employer is partially liable for the claim. Under the act, the fund is not an employer or insurer, and thus is exempt from liability. Under the act, any amount the Second Injury Fund is exempt from will be proportionally reallocated between the other insurers or former employers.

Retroactive Benefit Claims (§§ 2-7)
The act exempts the fund from any liability for retroactive benefit claims older than two years from the date on which the employer or its insurer paid benefits. It applies this liability limitation on workers' compensation death benefits, cost of living increases, benefits after a relapse, and cases of insolvent insurers.

Insolvent Insurer Claims (§ 7)
In situations where more than one employer is liable for compensation, the act exempts the fund from claims brought due to an insolvent insurer.

Insurance Guarantee Association (§ 12)
The act exempts the fund from claims by the Insurance Guarantee Association, another statutorily created entity that makes payments when an insurer goes bankrupt.

EMPLOYER ASSESSMENT (§ 8)
The act creates a new method for assessing employers and adds specifics to the definitions of "insured employer" and "self-insured employer. "

Under the act, an insured employer means an employer who insures its workers' compensation risks with an insurance company the state authorized to issue workers' compensation policies in Connecticut. It requires that a self-insured employer be one that the workers' compensation chairman has approved to self-insure

under the Workers' Compensation Act.

The act specifies that the treasurer must allocate the fund's assessments between self-insured employers and insured employers based on a percentage of paid losses (defined below) for each group for the preceding calendar year. The act prohibits credits taken against paid losses except:
1. voided checks for expenses paid under the workers' compensation act previously reported as a paid loss,
2. recoveries from third-party tortfeasors, and
3. reimbursement granted under the initial liability of last employer law and Second Injury Fund reimbursements.

Starting with policies effective July 1, 2006 or later, the assessment for insured employers will be based on the Second Injury Fund Surcharge Base (SIFSB), which the act defines as a direct written premium prior to application of any deductible policy premium credits. It specifies that a direct written premium means a premium based on policies prior to application of any deductible policy premium credits. Currently, the assessment for insured employers is based on a standard premium (not defined in law), which may include deductible premium credits and is subject to accounting adjustments that can delay payment to the Second Injury Fund. The act makes conforming changes replacing standard premium with the SIFSB.

By law and unchanged by the act, the fund assesses self-insured employers based on the employer's paid losses.

The act defines the Second Injury Fund Surcharge for insurance companies, interlocal risk management agencies, and self-insurance groups as the rate set by the treasurer multiplied by the SIFSB. For purposes of collecting the fund surcharge from insured employers and paying the surcharge to the fund, the act deems insurance companies to be collection agents of the Second Injury Fund. The insured employer is liable for paying the surcharge, and the insurance company must collect the payment and submit it to the fund.
The act allows, instead of requires, the treasurer to adopt regulations regarding assessing employers.

PAID LOSSES
The act defines employer paid losses as the total indemnity, medical, and any other expenses, prior to any credits or deductions, paid on or after January 1, 2006, by or on behalf of the employer to or on behalf of the injured employee. Paid losses include all legal expenses paid for benefits in accordance with workers' compensation law and any loss payments within deductible limits on workers' compensation insurance policies.

AUDITS, HEARINGS, AND PENALTIES (§§ 8 & 10)
The act gives the treasurer the authority to conduct periodic audits of any self-insured employer, group self-insured employer, insured employer, or insurance company regarding any information or payment the treasurer requires. The employer and insurer must provide all necessary documents and information the treasurer requires.

Audit periods cannot cover more than three years. But if the last audit was conducted less than three years earlier, the period of review must be from the date of the prior audit. If the audit determines repeated errors or underreporting by an employer or insurer, the fund may conduct an audit covering an additional two-year period.

If an audit indicates that an employer or insurer has not properly reported to the fund and, as a result, has underpaid its assessment, the treasurer can require the employer to pay the full amount of the assessment along with interest and penalty due not later than 30 days after the treasurer's notice.

FINES AND INTEREST PAYMENTS (§ 10)
The act establishes a fine at a rate of 15% of the unpaid assessment (or a minimum of $ 50) and an interest charge of 6% per year on any amounts owed as the result of an audit. Under current law, the treasurer can only charge interest at 15%, although in practice this is considered a fine. For self-insured employers, interest accrues 30 days after notice from the fund of the unpaid audit assessment. For insurance companies, the interest accrues from the date of the notice of audit errors or deficiencies as determined by

the postmark date.

Any partial payments made to the fund must first be applied to any unpaid penalty, then to any unpaid interest, and the remainder, if any, to the unpaid assessment. Interest or penalties will be applied if the fund receives assessment reports or payments postmarked after the designated due date.

INSURANCE CARRIER RESPONSIBILITIES (§ 8)
For insured employers, the act makes their insurers responsible for correct billing, timely collection, and timely payments to the fund. For insured employers, the SIFSB must be reported to the fund in the quarter the policy is effective, regardless of when the billing is sent or when the payment is made. Insurers must also report all endorsements, retrospective adjustments, and audits in the quarter the policy is issued. These requirements also apply to group self-insured employers.

STIPULATED AGREEMENTS AND SETTLEMENTS (§ 11)
Under the act, a workers' compensation commissioner may approve stipulated agreements (claim settlements) for benefits between an injured workers and the treasurer before or after an award or finding is issued against an employer, if the commissioner determines it is in the best interest of the injured worker. Notice of the proposed settlement must be sent to the employer by certified mail, return receipt requested to the last address on file with the secretary of the state or local postal authority. The commissioner must hold a hearing on the proposed settlement at the request of the employer in accordance with the workers' compensation law. If the employer does not file a written objection to the proposed settlement with the Workers' Compensation Commission within 28 days after the date of the settlement notice to the employer, the employer is deemed to have consented to the settlement and may not later contest the settlement terms. The settlement and its payments will be made by the fund if the employer is unable or fails to make such payments.

The act also provides that none of its provisions, or those existing in current law, precludes the treasurer from entering into an agreement with the employer for the reimbursement of expenses, costs, or benefits paid by the fund. The treasurer, the uninsured employer, the injured worker, or the injured worker's beneficiaries, or a liable third party may enter into a settlement agreement to finally or partially settle the rights and liabilities of any or all parties, subject to the approval of the commissioner.

AWARDS AND UNINSURED EMPLOYERS (§ 11)
Under the act, when a finding and award of compensation has been made against an uninsured employer who failed, neglected, refused, or is unable to pay it, the Second Injury Fund must pay the compensation and any type of benefit coming due as a consequence of the award. If there are further claims for any related, reasonable, and necessary treatment, the fund must provide payment to the claimant without an additional finding and award.

Public Act 05-233 (House Bill 5292)
An Act Concerning the Requirement that Prescriptions be Filled by Mail Order
(Signed by the Governor 07/11/05)

This act prohibits insurance policies that cover prescription drugs and are issued to individuals from requiring an insured person to receive prescriptions from a mail order pharmacy. The act applies to individual insurance policies delivered, issued, renewed, amended, or continued on or after July 1, 2005.

EFFECTIVE DATE: July 1, 2005

Public Act 05-238 (House Bill 6655)
An Act Concerning Groups Covered under the State Employee Health Plan and Association Group Plans
(Signed by the Governor 07/11/05)

This act requires the insurance commissioner to approve an insurance policy or contract, including one issued by an HMO, that offers a flexible plan design with respect to provider networks and enrollee cost-sharing, in certain circumstances.

The act expands eligibility for the Municipal Employee Health Insurance Program (MEHIP) to (1) individuals eligible for a retirement benefit from the Connecticut municipal employees' retirement system ("retired members") and (2) federally qualified nonprofit corporations that receive any public funding, or have federal 501(c)(5) tax-exempt status (e. g. , labor unions). It also broadens the types of nonprofit corporations with state contracts that are eligible to participate in MEHIP.

The act excludes small employer groups purchasing health insurance through MEHIP or an association group plan from the existing small employer rating law, which requires adjusted community rating, at the comptroller's or association group plan administrator's option, under certain circumstances. To use this option, (1) the MEHIP or association plans offered or issued must cover small employer groups as a single group and insure at least 10,000 individuals, (2) each small employer must be offered the same premium rates for each individual and dependent (i. e. , rated using a pure community rating methodology), and (3) the plans must be written on a guaranteed issue basis.

The act prohibits insurers from purchasing reinsurance coverage from the Connecticut Small Employer Health Reinsurance Pool for a small employer group that is offered pure community rates. Insurers can reinsure these groups, but must purchase the coverage through other avenues.

The act no longer requires small employer groups participating in MEHIP to be fully insured, at the discretion of the comptroller (e. g. , she can permit the groups to be self-insured). It also requires insurers to consider savings resulting from a reduction in an insurer's profits because of issuing plans for small employer groups through MEHIP or an association health plan when developing rates for small employers, as long as any loss in the insurer's overall revenue is not shifted to other small employers.

The act also (1) expands the list of plans that are exempt from the 1. 75% HMO premium tax, (2) excludes community action groups from the definition of small employer (thus exempting them from the small employer laws), and (3) makes technical and conforming changes.

EFFECTIVE DATE: Upon passage, except for the (1) premium tax exemptions, which are effective July 1, 2005 and apply to income years beginning on or after January 1, 2005 and (2) approval of policies with variable networks and enrollee cost-sharing provisions, which is effective October 1, 2005.

FLEXIBLE BENEFIT DESIGNS

The act requires the insurance commissioner to approve health insurance plans that offer a flexible plan design if the (1) policy or contract complies with all state insurance laws, (2) insurer or HMO files the policy or contract and associated rates with the insurance commissioner, and (3) rate filing demonstrates a reasonable premium rate reduction compared to a policy or contract that does not use the flexible design.

The act limits how an insurer or HMO can design a flexible benefits policy or contract. It can offer (1) a choice of different sized provider networks; (2) different deductibles depending on the type of health facility used; or (3) prescription drug benefits that use a combination of deductibles, coinsurance not to exceed 30%, or copayments, including combinations at different benefit levels.

PREMIUM TAX EXEMPTION

By law, HMOs must pay an annual premium tax of 1. 75% per contract or policy, except for contracts or policies issued to employees of municipalities and nonprofit organizations. The act also exempts from the tax any new or renewal contract or policy obtained through MEHIP and entered into after June 30, 2005 that provides coverage to (1) a community action agency's employees and their dependents, and (2) retired members and their dependents.

SMALL EMPLOYER

A "small employer" is an employer with one to 50 employees, including a self-employed person, other than a (1) private school obtaining health insurance through an association of private schools; (2) municipality participating in MEHIP; (3) nonprofit organization participating in MEHIP, unless the comptroller and the Office of Policy and Management secretary make a written request to the insurance commissioner to treat it as a small employer; and (4) personal care assistants association participating in MEHIP.

The act also excludes a community action agency from the definition. By law, a "community action agency" is a public or private nonprofit agency that has previously been designated by and authorized to accept funds from the federal Community Services Administration for community action agencies under the Economic Opportunity Act of 1964 or a successor agency.

BACKGROUND

MEHIP

MEHIP is a group health insurance program for municipal employees sponsored by the Office of the Comptroller and established by law. Subsequent laws expanded MEHIP eligibility to (1) nonprofit community action agencies, (2) state-contracted nonprofit corporations, (3) regional emergency telecommunications centers and tourism districts, and (4) small employers.

By law, participation in MEHIP must be voluntary. In addition, MEHIP must not affect the rates the state pays for state employee health plans and participants must pay all administration costs.

Community Rating—Pure and Adjusted

Pure community rating is the process of developing a uniform rate for all enrollees. An adjusted community rate modifies a community rate by specific case characteristics. "Case characteristics" are demographic or other objective characteristics of a small employer group's employees, including age, gender, family composition, location, size of group, administrative cost savings resulting from the administration of an association group plan or a plan written through MEHIP, and industry classification.

Connecticut Small Employer Health Reinsurance Pool

Reinsurance spreads a company's insurance risk by having one or more other companies assume some portion of the risk. The legislature created the Connecticut Small Employer Health Reinsurance Pool in 1990. All insurers issuing health insurance and insurance arrangements providing health plan benefits must be pool members. Pool members may purchase reinsurance coverage for a small employer group or individuals within a small employer group who are considered high risk. A high-risk individual is one who is likely to generate substantial claims due to his health status.

Public Act 05-253 (Senate Bill 1034)
An Act Establishing a Comprehensive Health Insurance Consumer Education Program
(Signed by the Governor 07/13/05)

This act requires the insurance commissioner, after consulting with the social services commissioner and the healthcare advocate (formerly called the managed care ombudsman), to develop a public education outreach program by January 1, 2006 to educate health care consumers about the various health care options in Connecticut.

The information must be posted on the Insurance Department's Internet web site and must refer to the availability of and general eligibility requirements for (1) programs administered by the Department of Social Services, such as Medicaid, HUSKY, and the state-administered general assistance (SAGA) program; (2) the Municipal Employee Health Insurance Program (MEHIP); (3) comprehensive health care plans; and (4) other coverage options offered through local, state, or federal agencies, or other Connecticut-licensed entities. The insurance commissioner must update the information at least quarterly.

The act also requires the comptroller to submit a report to the Insurance and Real Estate Committee by February 1, 2006 on the feasibility of making uninsured individuals eligible for MEHIP. "Uninsured individuals" include, at a minimum, residents without access to employer- or government-sponsored health insurance.

EFFECTIVE DATE: October 1, 2005, except the MEHIP study requirement, which is effective upon passage.

BACKGROUND
Related Act
PA 05-238 expands eligibility for MEHIP to (1) individuals eligible for a retirement benefit from the Connecticut municipal employees' retirement system and (2) federally qualified nonprofit corporations that have contracts with the state or receive any public funding, or have federal 501(c)(5) tax-exempt status (e. g. , labor unions).

Public Act 05-261 (Senate Bill 1350)
An Act Concerning the Interest Earned on Lawyers' Clients' Funds Accounts Program
(*Signed by the Governor 07/13/05)*

This act requires that, beginning July 1, 2005, each entity, other than a borrower, having an account established to receive loan proceeds from a mortgage lender participate in the Interest on Lawyers' Trust Accounts (IOLTA) program. It requires participating parties to deposit funds, regardless of the amount or period held, in special interest-bearing IOLTA accounts. The interest earned on such accounts is paid to a federally tax-exempt organization, which the Superior Court judges designate to administer the program.

The act defines a "mortgage lender" as any person engaged in the business of making first or secondary mortgage loans, including a bank or out-of-state bank; Connecticut, federal, or out-of-state credit union; and a first or second mortgage lender required to be licensed under state law.

The act specifies that the IOLTA law does not prevent an entity from depositing a person's loan proceeds, regardless of the amount or the period the proceeds are expected to be held, in a separate interest-bearing account established on behalf of and for the person's benefit.

The act also specifies that nothing in the IOLTA law grants to the judges of the Superior Court or any other judicial authority any legislative, regulatory, or rule-making authority over insurance companies.

EFFECTIVE DATE: July 1, 2005

Public Act 05-270 (House Bill 6865)
An Act Redefining Health Insurance Under Health Reinsurance Association Plans
(Signed by the Governor 07/13/05)

By law, insurers and HMOs issuing health insurance in the state and the Health Reinsurance Association, the state's high-risk pool, must offer comprehensive health care plans with specified minimum standard benefits. This act expands the types of insurance plans that are not considered "health insurance" for comprehensive health care plan purposes, thus potentially limiting the insurers and HMOs that must offer comprehensive health care plans. In addition to other plans excluded from the definition, the act excludes specified disease or limited benefit policies from the definition of "health insurance" for comprehensive health care plan purposes if a carrier offering such policies files information with the insurance commissioner each year before March 2 certifying that such policies are not substitutes for hospital and medical expense policies.

EFFECTIVE DATE: July 1, 2005

HEALTH INSURANCE DEFINITION
By law and for comprehensive health plan purposes, "health insurance" means hospital and medical expense policies, nonprofit service plan contracts, HMO contracts, and self-insured employee benefit plans.

Current law excludes accident only, disability, motor vehicle, and personal and commercial risk liability insurance from the definition.

This act specifies that, for comprehensive health plan purposes, "health insurance" excludes (1) accident only, credit, dental, vision, Medicare Supplement, long-term care, disability, or hospital indemnity plans; (2) supplemental coverage to liability insurance; (3) workers' compensation or similar insurance; (4) automobile medical-payments insurance; or (5) insurance coverage required by law in a liability insurance policy or similar self-insurance plan that pays beneficiaries regardless of fault.

It also excludes specified disease or limited benefit policies from the definition if a carrier offering such policies files certain information with the commissioner each year before March 2. This information includes (1) a statement certifying these policies are supplemental in nature and not substitutes for hospital or medical expense policies and (2) a summary of each policy, including the average annual premium rate or range of rates if premium varies by age, gender, or other factors. Carriers providing specified disease or limited benefit policies in the state for the first time must file the information at least 30 days before issuing or delivering such a policy in the state.

Public Act 05-271 (House Bill 6915)
An Act Concerning Portability Under Health Care Plans Issued through the Health Reinsurance Association
(Signed by the Governor 07/13/05)

This act requires comprehensive health care plans issued through the Health Reinsurance Association (HRA) to cover a preexisting condition for a group member or dependant who is newly insured on or after October 1, 2005, if the insured's qualifying former plan provided coverage for the condition. If the qualifying former plan did not cover the condition, the new HRA plan must credit the time the insured was covered under the former plan toward the HRA plan's exclusion period for a preexisting condition.

To be eligible for these provisions, the insured must apply for the HRA plan within 30 days of initial eligibility. In addition, his former plan must have terminated no more than 120 days before the effective date of the HRA plan (150 days if the termination was due to involuntary loss of employment), excluding any waiting period.

A qualifying former plan is (1) a group health insurance plan or arrangement, (2) a group self-insured plan, (3) Medicare or Medicaid, or (4) an individual insurance plan that provides benefits that are actuarially equivalent to or better than those provided by a small employer health care plan, as determined by the Insurance Department.

EFFECTIVE DATE: October 1, 2005

BACKGROUND

Health Reinsurance Association

The Health Reinsurance Association is a health insurance risk pool whose members consist of insurers, HMOs, and self-insurers doing business in Connecticut. It makes individual and group comprehensive health care plans available to people unable to obtain insurance coverage through other means. It administers a reinsurance program and pools risk among participating members. Members share association losses.

Comprehensive Health Care Plans

By law, all individual and group comprehensive health care plans must include specified minimum benefits, including coverage for catastrophic illness and a lifetime maximum coverage of $1 million. The plans may include cost containment features, such as preferred provider provisions and utilization review of health care services.

Related Act

PA 05-270 redefines “health insurance” for comprehensive health plan purposes.

Public Act 05-275 (Senate Bill 1052)
An Act Concerning Medical Malpractice
(Signed by the Governor 07/13/05)

This act makes numerous changes in the laws dealing with civil litigation, primarily relating to medical malpractice; medical malpractice insurance regulation and oversight; and the regulation, oversight, and disciplining of doctors.

Regarding litigation reform, the act:
1. permits claimants to pay more than the contingency fee sliding scale allows under certain circumstances, but prohibits a fee of more one-third of the settlement or the damages awarded (§1);
2. requires, as a condition of filing a medical malpractice lawsuit, a signed opinion from a similar health care provider indicating that malpractice has occurred (§ 2);
3. requires the court, within six months after a medical malpractice case is filed, to schedule a conference to determine whether to recommend it be designated as a complex litigation case and transferred to the complex litigation docket (§ 3)
4. changes the "offer of judgment" law in several ways including changing the terminology to "offer of compromise" and having the process end in a withdrawal of the lawsuit after payment instead of a judgment against the defendant (§ 4-7);
5. reduces the interest rate the court may award with respect to an offer of compromise for medical malpractice cases that accrue after September 30, 2005 from 12% to 8%, and establishes some additional requirements for such cases (§4)
6. allows defendants in medical malpractice cases that accrue after September 30, 2005, to introduce evidence of the amount of damages awarded to the plaintiff for the same injury or death by a court or jury in a separate lawsuit by the plaintiff against a different health care provider (In general, a cause of action accrues when the right to bring suit on a claim is complete.) (§8);
7. makes expressions of sympathy by health care providers inadmissible in lawsuits by victims of unanticipated outcomes of medical care (§ 9).
8. requires the court to review the evidence in medical malpractice cases that award $ 1 million or more in noneconomic damages to determine if the award is excessive as a matter of law
(§ 10);
9. eliminates the medical malpractice screening panels (§ 29).

Regarding insurance regulation and oversight, the act:
1. requires prior rate approval when an insurer wants to increase medical malpractice insurance rates by 7. 5% or more for physicians, hospitals, and certain other health care providers, and requires an insurer to notify insureds of (a) the proposed rate increase and (b) their right to request a hearing on the matter before the insurance commissioner (§ 11);
2. requires the insurance commissioner, by October 1, 2008, to review professional liability insurance rates to determine if to determine if (1) the amount or frequency of insured awards and settlements against these providers have decreased since October 1, 2005; (2) the rates reflect the decrease; and (3) the rates bear a reasonable relationship to the costs of writing such insurance in this state, and requires her to convene a working group to recommend appropriate changes to the law in decrease rates or establish reasonable rates if after review she determines that rates have not decreased and are not reasonably related to the costs of writing such insurance (§12);
3. requires the commissioner to develop a plan to maintain a viable medical malpractice insurance industry in Connecticut and submit it to the governor (§ 13);
4. requires insurers to report to the insurance commissioner on each malpractice claim that they close and requires her to compile and analyze the reported data, and report on it to the Insurance and Real Estate Committee and the public (§ 14); and
5. requires captive insurers to provide certain information to the insurance commissioner (§§ 15 and 16).

Regarding medical provider regulation and oversight, the act:

1. requires the Department of Public Health (DPH), to adopt guidelines for investigating complaints against, and disciplining, physicians (§§ 17 & 20);
2. expands the pool of people who may serve as members of DPH hearing panels from 18 to 24, specifies that at least eight, instead of eight, must be physicians, and at least one, instead of one, must be a physician assistant. , and requires that one member must be a physician or a physician assistant as appropriate (§ 18 & 19);
3. amends the physician profile law to require more information about adverse licensure actions in other states, professional liability insurance, and active involvement in patient care, and requires physicians to report any changes or updates in mandatory reporting information (§ 23);
4. establishes continuing education requirements for physicians as a condition of license renewal, along with exemptions from the requirements under certain conditions (§§ 21, 25,, 26); and
5. requires a physician whose license becomes void for failure to renew while on active duty in the armed forces to complete continuing education requirements in order to have his license renewed (§26);
6. requires each health care facility to develop surgery protocols by October 1, 2005 and the DPH commissioner to report on them to the Public Health Committee by that date (§ 27);
7. requires each hospital to contract with a patient safety organization, to gather medical or health care related data from the hospital and make recommendations to the hospital on ways to improve patient care and safety (§ 28).

EFFECTIVE DATE: Upon passage, except for the provision requiring captive insurers to provide information, which takes effect July 1, 2005, the provisions dealing with good faith certificates (2), (4), offer of compromise (4-7); collateral source (8), DPH disciplinary guidelines (17), continuing education (21, 25, 26), and the physician profile (23, 24) which take effect October 1, 2005; and the provision dealing with closed claims reports (14), which takes effect January 1, 2006.

FEES (§ 1)

Waiving Contingency Fee Limits

The law establishes a sliding scale of contingency fees attorneys may charge clients based on the amount of the settlement or judgment. It allows attorneys to collect (1) one-third of the first $ 300,000, (2) 25% of the next $ 300,000, (3) 20% of the next $ 300,000, (4) 15% of the next $ 300,000, and (5) 10% of amounts exceeding $ 1,200,000. This sliding scale applies to any lawsuit to recover damages resulting from personal injury, wrongful death, or property damage involving contingency fees, not just to medical malpractice cases. A Superior Court judge interpreted this law to allow clients to waive its protections and agree to pay a higher contingency fee.

The act allows a claimant in a claim or civil action that accrues on or after the date the act becomes effective to waive the benefit of the limitation contained in the sliding scale only if the claim is substantially complex, unique, or different from other claims as to warrant a deviation. The act specifies that factors that may indicate that a claim is substantially complex, unique, or different include, but are not limited to, whether it

1. involves complex factual, medical, or legal issues;
2. involves serious permanent personal injury or death;
3. is likely to require extensive investigation and discovery proceedings, including multiple depositions; or
4. requires testimony, whether at trial or in a deposition, from an expert who has not participated in the claimant's care or in any official investigation of the incident involved.

The act requires that before a claimant may enter into a contingency fee agreement that provides for a fee that exceeds the sliding scale, the attorney must (1) explain it and the reasons the attorney is unable to abide by it; (2) advise the claimant of his right to seek representation by another attorney willing to abide by the sliding scale; and (3) allow the claimant enough time to review the proposed agreement, and, if claimant wishes, seek representation by another attorney before entering into it.

The act makes any waiver of the sliding scale invalid unless the agreement (1) is in writing; (2) sets forth completely the sliding scale fee schedule; (3) contains a conspicuous statement containing certain information, printed in boldface type at least 12 points in size, in substantially the form the act specifies; and (4) is signed and acknowledged by the claimant before a notary public or other person authorized to

take acknowledgements.

The act requires that the conspicuous statement contain the following information:
1. The client understands that the sliding scale in statutes limits the amount of attorney's fees payable by a claimant and that the law establishing the sliding scale was intended to increase the portion of the judgment or settlement that a claimant actually receives and
2. despite the legislative intent in enacting that fee schedule was to confer a benefit on a claimant the client knowingly, and voluntarily waive that fee schedule in his claim or civil action.
If a claimant waives the sliding scale, the act limits the total fee under the contingency fee to one-third per cent of the damages awarded and received by the claimant or of the settlement amount received by the claimant and prohibits the firm from requiring the claimant to repay any costs that the attorney incurred in investigating and prosecuting the claim or civil action if there is no recovery.

The act specifies that no fee shall be payable to any attorney who seeks a fee that exceeds the sliding scale unless the claimant has waived it pursuant to the act's requirements and the contingency fee agreement complies with the act.

GOOD FAITH CERTIFICATE (§ 2)
The law prohibits filing malpractice lawsuits unless the attorney or claimant has made as reasonable an inquiry as permitted by the circumstances to determine that there are grounds for a good faith belief that the claimant received negligent care or treatment. The complaint or initial pleading must contain a certificate of the attorney or claimant that his inquiry resulted in a good faith belief that grounds exist for a lawsuit against each named defendant.

Under current law, a good faith belief can be shown if the claimant or his attorney receives a written opinion from a similar health care provider that there appears to be evidence of medical negligence. But it can also be shown in some other way. The act instead requires, for lawsuits filed after September 30, 2005, a written signed opinion from a similar health care provider in order to show good faith. The opinion must include the reasons for concluding that medical negligence occurred. It is not subject to discovery by the defendants except for questioning the certificate's validity.

The act makes the failure to obtain and file the written opinion grounds for the dismissing the case.

The act requires the claimant or his attorney to retain the original written opinion and attach a copy of it to the certificate, with the health care provider's name and signature removed.

The act imposes the same good faith certificate requirement on defendants who file an apportionment complaint against another health care provider. An apportionment complaint is a defendant's claim in a medical malpractice lawsuit that another health care provider who the plaintiff did not make a defendant committed malpractice and partially or totally caused the plaintiff's damages. By filing the apportionment complaint, the defendant in essence makes the other health care provider a party to the plaintiff's lawsuit.

The act makes the health care provider who provides the opinion immune from liability unless it is shown he acted with malice.

By law, the court may impose sanctions if a certificate is not made in good faith.
COMPLEX LITIGATION CASE (§ 3)
The act requires the court, within six months after a medical malpractice case is filed, to schedule a conference to determine whether to recommend to the chief court administrator, or his designee, that it be designated as a complex litigation case and transferred to the complex litigation docket. The act specifies that it does not prevent any party or a judge from, at any time, asking the chief court administrator to designate it as a complex litigation case.

OFFER OF COMPROMISE BY PLAINTIFFS AND DEFENDANTS (§§ 4- 7)
Contract Cases or Cases Seeking Money Judgments
By law, in any contract case or a case seeking money damages, plaintiffs and defendants can use a statutory

procedure to offer to settle the case for a specified amount. This is called an "offer of judgment."

Plaintiffs can file an offer of judgment with the court clerk up to 30 days before trial. After trial, the court must examine the record to determine whether the plaintiff made an offer of judgment that the defendant failed to accept. Under current law, if it determines that the plaintiff recovered an amount equal to or greater than the sum stated in his offer of judgment, the court must add 12% annual interest.

By law, a defendant has 60 days to file an acceptance of the offer with the court clerk. If the defendant notifies the clerk that he accepts the offer, the clerk must enter judgment.
Regarding lawsuits that accrue after September 30, 2005, the act makes several changes in this process. It reduces the interest the court must add from 12% to 8%. It prohibits the plaintiff from making the offer for at least 180 days after service of process on the defendant. It changes the terminology from "offer of judgment" to "offer of compromise," and gives the defendant 30 instead of 60 days to accept.

If the defendant accepts the offer, he must file his acceptance with the court clerk. After the plaintiff receives the amount specified in the offer from the defendant, he must file a withdrawal of the lawsuit with the clerk, which the clerk must record. Thus, no judgment is entered against the defendant.

By law, defendants may also file an offer with the court clerk up to 30 days before trial. The plaintiff has 10 days after being notified of the defendant's offer to accept it. If the plaintiff recovers less than the offer of judgment, he must pay the defendant's costs accruing after he received his offer, including reasonable attorney's fees up to $ 350.

The act changes the term "offer of judgment" to "offer of compromise" for this law also. It gives the plaintiff 60 days to accept the defendant's offer, instead of 10. After the plaintiff files an acceptance of an offer to compromise with the clerk and receives the amount specified in the offer, the plaintiff must file a withdrawal of the lawsuit with the clerk, who must record its withdrawal.

Medical Malpractice Cases
The act requires that, in medical malpractice cases, an offer of compromise must specify all damages then known to the plaintiff or his attorney when the offer is made. At least sixty days before filing the offer, the plaintiff or his attorney must provide the defendant or his attorney with an authorization to disclose medical records that meets federal health care privacy provisions under the Health Insurance Portability and Accountability Act of 1996 (also known as HIPAA), and disclose all expert witnesses who will testify as to the prevailing professional standard of care. The plaintiff must file with the court a certification that the plaintiff has provided each defendant or his attorney with all documentation supporting the damages.

EVIDENCE OF DAMAGES AWARDED (§ 8)
The act allows defendants in medical malpractice cases that accrue after September 30, 2005, to introduce evidence of the amount of damages awarded to the plaintiff for the same injury or death in a separate lawsuit the plaintiff filed against a different health care provider. (See Background for a list of the health care providers covered.)

EXPRESSIONS OF SYMPATHY (§ 9)
The act makes certain statements or other conduct inadmissible evidence as an admission of liability or an admission against interest in any medical malpractice lawsuit, or in any arbitration proceeding related to it. (See Background for a list of health care providers covered.) This rule applies to statements, affirmations, gestures, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence that a health care provider or his employee makes to the alleged victim, his relative, or representative regarding the victim's discomfort, pain, suffering, injury, or death as a result of the outcome of a medical treatment or procedure that differs from an expected result.

The victim's relatives include his spouse, parent, grandparent, stepfather, stepmother, child, grandchild, brother, sister, half-sibling, or his spouse's parents; relationships that are created by adoption; and any person who has a family-type relationship with a victim. A victim's representative is his legal guardian, attorney, health care agent, or any one else recognized in law or custom as a his agent.

MANDATORY REVIEW OF NONECOMOMIC DAMAGES OVER $ 1 MILLION (§ 10)

The act requires the court, in any medical malpractice case in which the jury awards more than $ 1 million in noneconomic damages, to review the evidence to determine if the amount is excessive as a matter of law. It requires the court to consider whether it so shocks the sense of justice as to compel the conclusion that the jury was influenced by partiality, prejudice, mistake, or corruption. If the court concludes the award was excessive, it must order the plaintiff to remit the excessive amount. If the plaintiff refuses to do so, the court must set aside the verdict and order a new trial.

PRIOR MALPRACTICE INSURANCE RATE APPROVAL (§ 11)

The act subjects malpractice insurance rates for physicians, hospitals, advanced practice registered nurses, and physician assistants to prior rate approval by the insurance commissioner. On and after the act's effective date, each insurer or rating organization seeking to increase its rates by 7 ½% or more must file a request with the Insurance Department and send, by certified mail with return receipt requested, written notice to all affected insureds at least 60 days before the change's effective date on a form the insurance commissioner prescribes.

The request for a rate increase must be filed after this notice is sent and must indicate the date the notice was sent. The notice must indicate that the insured can request a public hearing by submitting a written request to the insurance commissioner within 15 days after the date notice was sent. Within 15 days after notice is sent, the insurer must give the Insurance Department a list of insured's to whom notice was sent and indicate whether a return receipt was received for each.

The act prohibits the insurance commissioner from approving, modifying, or denying a requested rate increase the time period for insureds to request a hearing expires. It requires the commissioner to hold a public hearing, if requested, before taking action.

The commissioner must approve, modify, or deny the filing within 45 days after receipt. Her final decision may be appealed to Superior Court.

INSURANCE COMMISSIONER REVIEW OF MALPRACTICE INSURANCE RATES (§12)

By October 1, 2008, the act requires the insurance commissioner to review medical malpractice insurance rates in Connecticut for physicians, hospitals, advanced practice registered nurses, and physicians' assistants to determine if (1) the amount or frequency of insured awards and settlements against these providers have decreased since October 1, 2005; (2) the rates reflect the decrease; and (3) the rates bear a reasonable relationship to the costs of writing such insurance in this state. She must examine the rates for policies issued by (1) captive insurers and risk retention groups, to the extent this information is available, and (2) insurers licensed in Connecticut.

If the commissioner determines that rates have not decreased and are not reasonably related to the costs of writing such insurance in the state, she must convene a working group to (1) consider the amounts of awards and settlements in the past 10 years and (2) recommend appropriate changes, if any, in the law to decrease rates or establish reasonable ones. These changes may include reasonable limits on noneconomic damages awards, revisions to procedures insurers use to establish rates, and regulation of reimbursement rates health insurers and HMOs pay to health care providers.

The working group must consist of:

1. the chairmen and ranking members of the Judiciary, Public Health, Insurance and Real Estate, and the Legislative Program Review and Investigations committees;
2. one member each appointed by the Connecticut Medical Society, the Connecticut Hospital Association, and the Connecticut Trial Lawyers Association;
3. one representative of a patient advocacy group appointed by the House speaker;
4. one representative of a medical malpractice insurer licensed and actively doing business in Connecticut appointed by the Senate president pro tempore;
5. the commissioner of the Office of Health Care Access, or a designee; and

6. the insurance commissioner.

PLAN TO MAINTAIN A VIABLE MEDICAL MALPRACTICE INSURANCE INDUSTRY (§ 13)

By January 1, 2006, the insurance commissioner must develop and submit to the governor a plan to maintain a viable medical malpractice insurance industry in Connecticut for physicians, hospitals, advanced practice registered nurses, and physician assistants.

MEDICAL MALPRACTICE DATA BASE-CLOSED CLAIM REPORTS (§ 14)

Closed Claim Reports

Current law authorizes the insurance commissioner to require all medical malpractice insurers in Connecticut to submit whatever information she deems necessary to establish a medical malpractice database. The database can include information on all incidents of medical malpractice, all settlements, all awards, other information relative to procedures and specialties involved, and any other information relating to risk management.

The act instead requires, beginning January 1, 2006, each insurer (including captive insurers and self-insured entities) provide to the commissioner a closed claim report, on whatever form she requires. A "closed claim" is one that has been settled or otherwise disposed of, where the insurer has paid all claims regarding physicians, hospitals, advanced practice registered nurses, and physician assistants.

The act requires the insurer to report within 10 days after the end of the calendar quarter in which a claim is closed. The report must include information only about claims settled under Connecticut's laws. It must include details about the insured and insurer, the injury or loss, the claims process, and the amount paid on the claim.

Details About the Insured and Insurer

The report must include the (1) insurer's name; (2) policy limits and whether it was an occurrence policy or was issued on a claims-made basis; (3) insured's name, address, license number, and specialty coverage; and (4) insured's policy number and unique claim number. An "occurrence policy" provides protection for malpractice that occurred during the time the policy was in effect. A "claims-made" policy provides protection for claims made during the period the policy is in effect.

Details About the Injury or Loss

The report must specify the

1. date of the injury or loss that was the basis of the claim;
2. date the injury or loss was reported to the insurer;
3. name of the institution or location where the injury or loss occurred;
4. type of injury or loss, including an injury severity rating that corresponds with the injury scale that the commissioner must establish based on the severity scale developed by the National Association of Insurance Commissioners; and
5. name, age, and gender of any injured person covered by the claim.

Any individually identifiable information (as defined by federal regulation) is confidential. The act specifies that reporting this information is required by law. It requires that if necessary to comply with federal privacy laws, the insured must arrange with the insurer to release the required information.

Details About the Claims Process

The report must contain details about the claims process including:

1. whether a lawsuit was filed, and if so, in which court;
2. its outcome;
3. the number of other defendants, if any;
4. the stage in the process when the claim was closed;
5. the trial dates;
6. the date of any judgment or settlement;
7. whether an appeal was filed, and if so, the date filed;
8. the resolution of the appeal and the date it was decided;

9. the date the claim was closed; and
10. the initial and final indemnity and expense reserve for the claim.

Details About the Amount Paid on the Claim
The report must include:
1. the total amount of the initial judgment rendered by a jury or awarded by the court;
2. the total amount of the settlement if no judgment was rendered or awarded or the claim was settled after judgment was rendered or awarded;
3. the amount of economic and noneconomic damages, or the insurer's estimate of these amounts in a settlement;
4. the amount of any interest awarded due to failure to accept an offer of judgment;
5. the amount of any remittitur (reduction) or additur (addition) and the amount of final judgment after such reductions or additions;
6. the amount the insurer paid;
7. the amount the defendant paid due to a deductible or a judgment or settlement in excess of policy limits;
8. the amount other insurers or other defendants paid;
9. whether a structured settlement was used;
10. the expense assigned to and recorded with the claim, including defense and investigation costs but not including the actual claim payment; and
11. any other information the commissioner determines necessary to regulate the medical malpractice insurance industry, ensure its solvency, and ensure that such liability insurance is available and affordable.
The act requires the commissioner to establish a closed claim reports electronic database.

Annual Data Summary
The act requires the insurance commissioner to aggregate the data in individual closed claim reports into a summary and annually report the summary data. The report must analyze the closed claim information, including
1. a minimum of five years of comparative data, when available;
2. trends in frequency and severity of claims;
3. itemization of damages;
4. timeliness of the claims process; and
5. any other descriptive or analytical information that would help interpret the trends in closed claims.

The annual report must include a summary of rate filings for medical malpractice insurance for medical professionals and entities that the department approved for the prior calendar year. The summary must include an analysis of the trend of direct losses, incurred losses, earned premiums, and investment income as compared to prior years. The report must also include base premiums charged by medical malpractice insurers for each specialty and the number of providers insured by specialty for each insurer.

Beginning March 15, 2007, the commissioner must annually submit the report to the Insurance and Real Estate Committee. She must also (1) make the report available to the public, (2) post it on the department's Internet site, and (3) provide public access to the contents of the electronic database after establishing that the names and other individually identifiable information about claimants and practitioners have been removed.

The act requires the commissioner to provide the DPH commissioner with electronic access to all the closed case information she receives. It also requires the DPH commissioner to keep such information as confidential as the law requires the insurance commissioner to do.

CAPTIVE INSURERS (§§ 15 AND 16)
A "captive insurer" is an insurance company owned by another organization and whose primary purpose is to insure risks of the parent organization and affiliated companies. In the case of groups and associations, it is an insurance organization owned by the insureds whose primary purpose is to insure risks of member organizations, group members, and their affiliates.

The act requires each captive insurer that offers, renews, or continues insurance in Connecticut to provide

the following information to the insurance commissioner in the same manner required for risk retention groups:
1. a copy of the group's financial statement submitted to its state of domicile, which must be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist;
2. a copy of each examination of the captive as certified by the commissioner or public official conducting the examination; and
3. at the commissioner's request, a copy of any audit performed with respect to the captive.
If a captive insurer does not maintain this information in this form, the act permits it to submit the information to the commissioner on whatever form she prescribes.

The act requires the commissioner to act as agent for service of process for risk retention groups domiciled outside the United States and for captive insurers. By law, the commissioner acts as agent for risk retention groups domiciled in another state that offer insurance in Connecticut.

BACKGROUND

"Similar Health Care Provider"

By law, if the defendant health care provider is not certified by the appropriate American board as a specialist, is not trained and experienced in a medical specialty, or does not hold himself out as a specialist, a "similar health care provider" is one who is (1) licensed by the appropriate regulatory agency of this state or another state requiring the same or greater qualifications and (2) trained and experienced in the same discipline or school of practice. Such training and experience must be a result of active involvement in the practice or teaching of medicine within the five-year period before the incident giving rise to the claim.

If the defendant health care provider is certified by the appropriate American board as a specialist, is trained and experienced in a medical specialty, or holds himself out as a specialist, a "similar health care provider" is one who is (1) trained and experienced in the same specialty and (2) certified by the appropriate American board in the same specialty. But, if the defendant health care provider is providing treatment or diagnosis for a condition that is not within his specialty, a similar health care provider is a specialist trained in the treatment or diagnosis of that condition.

Sanctions if Certificate Not Filed in Good Faith

By law, the court must impose an appropriate sanction on the person who signed the certificate if it determines, after discovery is completed, that the certificate was not made in good faith and that no valid issue was presented against a health care provider who fully cooperated in providing informal discovery. It may also sanction the claimant. The sanction may include an order to pay to the other party or parties the reasonable expenses incurred because of the filing of the pleading, motion, or other paper, including a reasonable attorney's fee. The court also may submit the matter to the appropriate authority for disciplinary review of a claimant's attorney who submitted the certificate.

Licensed Health Care Providers and Institutions

The provisions of the act relating to evidence of damages awarded (§ 8) and expressions of sympathy (§ 9), apply to medical malpractice lawsuits filed against the following licensed health care providers:
1. doctors and surgeons,
2. chiropractors,
3. natureopaths,
4. podiatrists,
5. athletic trainers,
6. physical and occupational therapists,
7. substance abuse counselors,
8. radiographers and radiologic technologists,
9. midwives,
10. nurses and nurses aides,
11. dentists and dental hygienists,
12. optometrists and opticians,
13. respiratory care practitioners,

14. pharmacists,
15. psychologists,
16. marital therapists and professional counselors, and
17. clinical social workers.

The provision dealing with expressions of sympathy also apply to lawsuits against
1. veterinarians,
2. massage therapists,
3. electrologists,
4. hearing instrument specialists and audiologists,
5. ambulance drivers, and
6. emergency medical technicians and communications personnel.

The provisions also apply to the following health care institutions: hospitals; outpatient surgical facilities; residential care homes; health care facilities for the handicapped; nursing homes; rest homes; home health and homemaker-home health aide agencies; mental health and substance abuse treatment facilities; college infirmaries; diagnostic and treatment facilities, including those operated and maintained by a state agency, except facilities for the care or treatment of mentally ill or substance abusing people; and intermediate care facilities for the mentally retarded.

Public Act 05-282 (Senate Bill 1102)

An Act Concerning Enforcement of Mandatory Insurance Requirements for Motor Vehicles

(Signed by the Governor 07/13/05)

This act replaces the statutorily required registration cancellation mechanism the Department of Motor Vehicles (DMV) uses for vehicles operating without required insurance coverage with DMV's standard registration suspension process. It also increases, from $100 to $200, the civil penalty a vehicle owner must pay when he enters a consent agreement with DMV for reinstatement of registration after DMV imposes the registration sanction and the owner provides satisfactory evidence of mandatory security.

EFFECTIVE DATE: October 1, 2005

REGISTRATION SANCTION FOR FAILURE TO MAINTAIN INSURANCE COVERAGE

By law, private passenger motor vehicles and vehicles with commercial registrations cannot be operated in Connecticut unless the vehicle owner has insurance meeting minimum statutory requirements. Periodically, vehicle insurers must provide DMV with data identifying vehicles for which they have cancelled coverage. This data is compared to active vehicle registrations to determine vehicles potentially operating without the required insurance.

When DMV finds that a vehicle owner failed to maintain required insurance coverage throughout the vehicle's registration period, prior law prescribed a specific process it had to follow to cancel the vehicle's registration. This process was different and distinct from the process DMV uses to suspend vehicle registrations for other reasons. The act replaces the registration cancellation procedure with DMV's suspension process.

Previous Cancellation Process

Under the previous cancellation sanction for uninsured vehicles, DMV sent a notice of registration cancellation to the vehicle owner notifying him that (1) after the cancellation was final and effective the vehicle was subject to seizure, impoundment, and potential forfeiture if seen operating on a public highway or in a public parking area and (2) he could return the marker plates and registration to avoid impoundment and suspension of his driver's license. The registration cancellation was final and effective 14 days after the notice was mailed.

If the owner contended that coverage had been maintained throughout the registration period, he could contact DMV at least two days before the effective date of the cancellation to request an administrative hearing. The cancellation was stayed upon such request pending the final decision. The hearing had to be

scheduled promptly but was limited to determining if the person was the registered owner of the vehicle in question and if he failed to maintain coverage throughout the registration period. The cancellation was upheld unless the commissioner or designated hearing officer found either assertion was not true. The commissioner's final decision had to be mailed to the owner no more than 30 days from conclusion of the hearing, and cancellation, if upheld, became effective three days after the mailing date.

If, before the cancellation became final, the owner did not contest the determination that he had failed to maintain insurance and provided DMV with satisfactory evidence that he currently had insurance coverage, he could enter into a consent agreement with DMV and pay a $100 fee. Entrance into a consent agreement resulted in a termination of the cancellation order or rescission of a cancellation previously imposed unless the commissioner determined that the owner failed to maintain insurance or could not satisfy the commissioner that he had maintained it continuously after the effective date of the agreement.

The owner of the vehicle with a cancelled registration was not eligible to get a new registration for it, or a new or renewal registration for any other motor vehicle in his name, until he appeared personally at DMV and (1) completed a registration application, (2) furnished proof of insurance, and (3) paid a $250 restoration fee for the first 31 days, or any part thereof, that the registration was cancelled and $5 for each additional day up to 90 days ($545). This fee was in addition to any other fees required to obtain a new registration. The commissioner could reduce the restoration fee to $100 if he found that the vehicle was not operated during the cancellation period and during the period the owner failed to maintain the insurance.

New Registration Suspension Process
The act eliminates this process and replaces it with registration suspension according to DMV's established process. But it keeps (1) the driver's license suspension as a potential sanction, imposing it if the vehicle owner has not entered into a consent agreement with DMV, cancelled the vehicle's registration, or transferred ownership of the vehicle within 30 days after the date of the registration suspension and (2) the consent agreement process.

In addition, the act maintains (1) the existing authority for police to seize and impound a vehicle observed operating with a suspended registration, (2) payment of a $50 confiscation fee, and (3) the requirement that a vehicle impounded for more than 45 days is subject to forfeiture to the state.

The act increases the penalty the vehicle owner must pay from $100 to $200 if he enters a consent agreement with DMV.

The act requires cancellation notices insurers may send to their policyholders to reflect the changed requirements the act imposes.

Budget Implementers of Interest

Public Act 05-272 (House Bill 6713)
An Act Concerning Revisions to the Department of Public Health Statutes
(Signed by the Governor 07/13/05)

This act makes a number of substantive and technical changes related to various health care practitioners, institutions, and activities regulated by the Department of Public Health (DPH), Department of Social Services (DSS), and the Department of Consumer Protection (DCP). Only sections that would be of interest to Insurance Department staff were included.

EFFECTIVE DATE: see individual sections as noted throughout the bill analysis.

BREAST CANCER SCREENING (§ 30)
By October 1, 2005, the act requires the best practices subcommittee of DPH's Quality of Care Advisory Committee to review and make recommendations, by January 1, 2006, concerning best practices with

respect to when breast cancer screening should be done using comprehensive ultrasound screening or mammogram examinations.
Effective Date: October 1, 2005

Public Act 05-280 (House Bill 7000)
An Act Concerning Social Services and Public Health Budget
(Signed by the Governor 07/13/05)

This budget implementing act is voluminous. Therefore, only excerpts, which may be of interest to Insurance Department staff, have been included in this summary.

RESTORING PRESUMPTIVE ELIGIBILITY FOR HUSKY A CHILDREN, CONTRACTS FOR SERVICES, CHANGING MANAGED CARE PLANS, AND TECHNICAL CHANGE (§ 9)

Presumptive Eligibility
The act requires the DSS commissioner to reinstitute PE for children applying for HUSKY A coverage. PE determinations must be made in accordance with applicable federal law. (In essence, PE enables children to start getting HUSKY A coverage while DSS is in the process of completing the eligibility determination.)

It requires DSS to adopt regulations to establish standards and procedures for designating organizations as "qualified entities" to grant PE. These entities must ensure that at the time they grant PE, a completed Medicaid application is submitted to DSS for a full eligibility determination. In adopting the standards and procedures, DSS must ensure representation of statewide and local organizations that provide services to children.

PA 03-3, June 30 Special Session, eliminated PE for HUSKY A children. Until then, DSS used qualified entities to make PE determinations, using the same requirements as those required in the act.

Contractor for Medicaid Managed Care (HUSKY A) and HUSKY B Services
By law, DSS must contract with an entity to be a single point of entry "servicer" for HUSKY A and B applicants and enrollees. In addition to providing enrollment assistance, the servicer must do outreach and provide public information about these programs. DSS currently contracts with ACS, Inc.

The act requires DSS, when its existing contract expires, to develop one or more new contracts for single point of entry services and managed care enrollment brokering. It also allows it to enter into more than one contract, the duration of which cannot exceed seven years. The ACS contract, in place since 1995, expired in December 2004. It has never been formally re-bid.

Any future contract must include performance measures, including (1) time limits for processing applications, (2) parameters establishing requirements for completed and "reviewable" applications, and (3) the percentage of applications forwarded to DSS in a complete and timely fashion. The contracts must also include a process for identifying and correcting noncompliance with performance measures, including sanctions when continued noncompliance occurs.

Enrollees' Ability to Change MCOs
The act requires HUSKY A and B beneficiaries to remain enrolled in a managed care plan for 12 months before they can switch to another plan, unless (1) they can demonstrate good cause for switching sooner or (2) the beneficiary no longer meets the program's eligibility requirements. Under current DSS regulations, HUSKY B enrollees may only switch plans once a year. HUSKY A enrollees can switch more often.

Repeal of HUSKY B Commercial Comparability Requirement
The act repeals language that requires the services and cost sharing requirements in HUSKY B to be substantially similar to those offered by the largest commercially available health plan offered by a managed care organization to state residents.

EFFECTIVE DATE: July 1, 2005

STATE RESPONSE TO FEDERAL MEDICARE PART D PRESCRIPTION PLANS (§ 19-30)

The permanent federal Medicare Part D program, which begins January 2006, allows Medicare beneficiaries to voluntarily enroll in Medicare-approved private prescription plans. The plans must provide at least a specified "standard" package of benefits to all Medicare beneficiaries. The standard benefits (for people who are not on ConnPACE or dually eligible for Medicare and Medicaid) consist of at least: (1) 75% coverage of prescription costs up to $ 2,250 with a $ 250 annual deductible; (2) no coverage beyond the $ 2,250 threshold until the beneficiary has spent a total of $ 3,600 in out-of-pocket costs ($ 5,100 in total consumer and Medicare expenditures), known as the "gap in standard coverage" or, informally "the donut hole; " and (3) "catastrophic coverage" of 95% of all prescription costs above $ 5,100 (the beneficiary pays the greater of 5% of the cost per prescription or $ 2 for generic or preferred drugs and $ 5 for others). The plans may charge a monthly premium that can vary, but is expected to be about $ 37.

Under the federal law, Medicare beneficiaries with low incomes and assets and those who are Medicare-Medicaid dually eligible will receive varying additional subsidies which involve lower deductibles and premiums or none at all, lower copays, and coverage for the "donut hole. "

Not all prescription drugs are covered, only those designated as "Medicare Part D covered drugs." In addition, the private plans can choose which of the Part D covered drugs they will offer on their formularies. Under a federal exception process, people can appeal the plan's decisions and, if they win, the drugs in question can be treated and paid for as though they were on the formulary.

This act responds to the federal legislation by modifying state law concerning (1) the Connecticut Pharmaceutical Contract to the Elderly and Disabled (ConnPACE) program and (2) Medicaid prescription coverage for people who are fully eligible for both the Medicare and Medicaid programs (the "dually eligible"). It also makes related changes for Department of Mental Retardation and Department of Mental Health and Addiction Services clients.

ConnPACE

The act coordinates the Medicare Part D benefits with the state's ConnPACE program so that no ConnPACE beneficiaries will pay more than the current $ 16. 25 per-prescription copayment and the $ 30 annual registration fee for drugs that are (1) preferred drugs on their Part D prescription plan's formulary or (2) not designated a Part D covered drug. Beneficiaries may pay less than the $ 16. 25 copay if the required Part D copays are lower. When a drug is a Medicare-covered drug but is not a preferred drug on the particular plan's formulary, the act allows DSS to pay for it at the lower of several alternative prices and makes the client responsible for paying the difference and the usual ConnPACE copay. DSS generally pays nothing for Part D covered drugs that are not on a plan's formulary, but under the federal exception procedure, if the client or DSS appeals and wins, drugs not on the formulary could be treated and paid for as though they were on it.

Under the act, DSS pays the Medicare Part D plan monthly premiums for ConnPACE recipients who are subject to them. It will cover drugs to the same extent as otherwise during the federal deductible period and the gap ("donut hole") in the standard Medicare Part D plan.

The act requires ConnPACE participants to (1) enroll in one of the Medicare Part D plans as a condition of receiving ConnPACE benefits; (2) disclose their income and assets to DSS as a means of determining whether they are eligible for federal low-income subsidies; and (3) appoint the DSS commissioner as their authorized representative, who can place them in a plan if they do not choose one in a timely manner.

Medicare-Medicaid Dually Eligible

Under the federal law, Medicare-Medicaid dually eligible beneficiaries will no longer receive their prescription coverage through Medicaid for drugs designated as "Medicare Part D covered drugs. " Federal law allows them to choose a Medicare Part D plan and provides them with varying levels of extra subsidies compared to the "standard" Part D plan.

The act makes separate provision for these "dually eligibles. " They will no longer receive Medicaid benefits for drugs that could be covered under Medicare Part D, even if these covered drugs are not on the chosen plan's formulary. For the drugs that are on their plan's formulary, they will have to pay the new federal copays for this specific group, varying from $ 1 to $ 5 depending on their income and the type of drug (generic/preferred or other). Currently, there are no prescription copays under Medicaid in Connecticut. But this group will still receive Medicaid coverage for drugs that are not covered by Part D.

Medicaid Coverage Eliminated For Part D Drugs; Continued For Non-Part D Drugs (§ 19)
Under this section, Medicaid will no longer cover prescription drugs that could be covered under Medicare Part D for Medicaid recipients who are also eligible for Part D coverage, starting when that program begins. It specifies that Medicaid coverage will be provided for prescription drugs that are not Medicare Part D drugs as defined in the new federal law.

The federal law and regulations define "Medicare covered Part D drug" as a prescription drug, a biological product, insulin and related medical supplies, or vaccines, if they are used for a medically accepted indication. It excludes drugs available under Medicare Part A (hospital) or Part B (which has very limited outpatient coverage for a few items such as chemotherapy) and certain drugs such as over-the counter drugs, which may be excluded from or restricted under Medicaid coverage. (42 CFR 423. 100. FR 1/28/05, p. 4534)

EFFECTIVE DATE: July 1, 2005

NUTMEG HEALTH PARTNERSHIP INSURANCE PLAN (§ 36)
The act requires the Insurance and Real Estate Committee to study the possible implementation of a "Nutmeg Health Partnership Insurance Plan," a joint public-private initiative. The committee must study ways, and develop a plan, to (1) increase the number of residents with health insurance, (2) provide broader health care access, and (3) make health care more affordable. By February 1, 2006, the committee must submit a report to the General Assembly that details the plan and considers legislation to implement it.

EFFECTIVE DATE: July 1, 2005

HEALTH INSURANCE FOR PEOPLE WITH HIV OR AIDS (§ 42)
The act requires the DSS commissioner, by January 1, 2006, to report to the Public Health, Human Services, and Appropriations committees on the feasibility and costs of establishing a program to purchase and continue health insurance policies for people with HIV or AIDS that would use the same eligibility criteria DSS uses for its AIDS drug assistance program.
DSS' Connecticut AIDS Drug Assistance Program is for people with HIV or AIDS. DSS pays the costs of drugs needed to treat the illness for people with incomes up to 400% of the FPL ($ 38,280 annually for one person).

EFFECTIVE DATE: Upon passage

DEPARTMENT ON AGING 2007 REESTABLISHMENT AND TASK FORCE (§§ 53-54)
The act establishes a Department on Aging, headed by a commissioner on aging appointed by the governor. It requires the commissioner to serve full-time and be knowledgeable and experienced in the conditions and needs of the elderly. He must administer all laws under the department's jurisdiction and use the most efficient and practical means to provide care for and protection of elderly persons. The act requires the commissioner to:
1. administer, coordinate, and direct department operations;
2. adopt and enforce regulations;
3. establish rules for the department's internal operation and administration;
4. plan for, establish, and develop programs, administer services, and enter into contracts to achieve the department's purposes;
5. advocate for additional needed comprehensive and coordinated programs for the elderly;
6. assist and advise all appropriate state, federal, local, and area planning agencies for the elderly in the performance of their functions and duties under federal law;
7. coordinate outreach activities by public and private agencies serving the elderly; and

8. consult and cooperate with area and private planning agencies.

The act transfers the functions, powers, duties, and personnel of the DSS Division of Elderly Services to the Department on Aging. (This DSS division was recently merged into a larger Bureau of Aging, Community, and Social Work Services.) It continues in force relevant DSS and Commission on Aging orders and regulations in effect on January 1, 2007, until they are amended, repealed, or superseded.

EFFECTIVE DATE: January 1, 2007

CRITICAL ACCESS HOSPITAL (§§ 57-67)

Definitions (§§ 60-61)

The bill includes "critical access hospital " under the category of "health care institution" for DPH regulatory purposes and defines it as a facility used intermittently, deployed at the discretion of the governor, or her designee, for training purposes in the event of a public health or other emergency for isolation purposes or triage and treatment during a mass casualty event.

EFFECTIVE DATE: July 1, 2005

Board of Directors (§ 57)

The bill establishes a board of directors to advise DPH on the operations of the critical access hospital. The board includes the commissioners of public health, emergency management and homeland services, and social services or their designees, the OPM secretary or his designee, the adjutant general or his designee, one representative of a hospital with over 500 licensed beds and one from a hospital with 500 or fewer beds, both appointed by the health commissioner. The DPH commissioner is the board's chairperson. The board must adopt bylaws and meet as specified by the bylaws and as deemed necessary by the DPH commissioner. The board must advise DPH on operating policies and procedures; facility deployment and operation; appropriate facility utilization; clinical programs and delivery of patient services; staffing patterns and ratios; human resources; standards and accreditation guidelines; staff credentialing; patient admission, transfer and discharge policies; quality assurance and performance improvement; patient rates and billing and reimbursement mechanisms; staff education and training; and alternative facility uses.

EFFECTIVE DATE: July 1, 2005

Certificate of Need Exemption (§ 58-59)

The bill exempts a critical access hospital from the state's certificate of need (CON) law as administered by the Office of Health Care Access. Also, any additional critical access hospital beds and related equipment obtained to enhance the state's bed surge capacity or providing isolation care under the state's health preparedness planning activities is exempt from CON (§ 37-38).

Critical Access Hospital Account (§§ 62-63)

The bill establishes a critical access hospital account as a separate, nonlapsing account within the general fund. The money in the account must be used by DSS to fund the operations of the critical access hospital in the event of activation. The account contains all funds required by law to be deposited in it. The sum of $ 1 is appropriated to DSS from the general Fund for FY 06 for deposit into the account and $ 1 for FY 07.

EFFECTIVE DATE: July 1, 2005

Health Insurance Coverage (§§ 64-65)

The bill requires all individual and group health insurance policies delivered, issued for delivery, renewed, amended or continued in the state as of July 1, 2005 to provide benefits for isolation care and emergency services provided by the state's critical access hospital. The benefits are subject to any policy provisions that apply to other services covered by the policy. The rates paid by individual and group policies under this provision must be equal to the rates paid under Medicaid as determined by DSS.

EFFECTIVE DATE: July 1, 2005

PRESCRIPTION DRUG PURCHASING PROGRAM (§ 68)

The bill requires the public health commissioner, in conjunction with the Public Health Committee chairpersons, to convene a working group to study whether the state should contract for development of a prescription drug purchasing program or enter into an existing program, that allows Connecticut residents to purchase drugs through pharmacies in Canada or other countries. The working group's membership includes the commissioner or his designee, the health committee chairpersons or their designees, the Attorney General or his designee, an OPM representative, and any other person the health commissioner and chairpersons deem necessary.

The study must evaluate any new or existing prescription drug program that would allow Connecticut residents to purchase drugs through Canadian pharmacies or those in other countries to assess (1) whether it would meet all of the current levels of safety and quality assurance afforded Connecticut residents concerning prescription drug purchasing and whether it would provide state residents who enroll access to more affordable drugs and (2) whether Connecticut residents would be required to compromise any legal rights as condition of program participation. The study must also examine and make recommendations concerning the parameters of a request for proposal to solicit the implementation of a program in Connecticut. DPH can enter into contracts with consultants to assist with the study.

The health commissioner must report by January 1, 2006 to the Public Health and Appropriations committees on the study results.

EFFECTIVE DATE: Upon passage.

INSURANCE PRACTICES (§ 89)
The bill requires the managed care ombudsman, by October 1, 2005 and in consultation with the Strategy Board, to establish a process for mental health care providers, patients, business organizations, and managed care organizations to communicate about and ensure:

1. compliance with state insurance laws governing (a) compliance with federal law on guaranteed availability and renewability of coverage, mental health parity, and discrimination based on health status, (b) standards concerning psychotropic drug coverage, (c) mental health parity, and (d) coverage continuation for children with mental disabilities;
2. best practices in mental health treatment and recovery (presumably to assure that these practices are followed); and
3. the relative costs and benefits of providing effective mental health coverage to employees and their families (it is not clear what is to be assured by this provision).

The ombudsman must report annually to the Public Health and Insurance committees, beginning January 1, 2006, on his implementing this requirement.

EFFECTIVE DATE: Upon passage