CONNECTICUT INSURANCE DEPARTMENT

LEGISLATIVE SUMMARY

JUNE 2006

Connecticut Insurance Department
2006 Legislative Summary

Foreword

The following public act summaries were written by the Legislative Commissioner's Office and the Office of Legislative Research. Only public acts affecting, or of interest to, the Insurance Department are included in this document. Public acts are not listed numerically but rather by department division and in order of those public acts having the most direct impact on the agency's operations or regulatory authority. *This document is not intended to convey legal advice on the content of the public acts.*

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Acts Proposed by the Insurance Department

Public Act 06-54 (Senate Bill No. 554)
An Act Making Revisions to the Insurance Statutes
(Signed by the Governor 5/8/2006)

This act makes a number of substantive and technical revisions to the insurance statutes. It (1) increases the time the insurance commissioner has to hear and decide contested cases related to denied licenses, rates, or forms; (2) allows an insurer to invest in its affiliates, subject to the same limitations and requirements that apply to investments in subsidiaries; (3) requires a managed care organization (MCO) or health insurer to provide information regarding a self-insured governmental health plan under which an appeal is made within five business days of receiving a request and to notify the plan sponsor that it must send a copy of the policy or contract; and (4) requires a licensed practitioner of the healing arts, instead of the medical arts, to certify a utilization review company's decision following an appeal to not authorize an admission, service, procedure, or extended hospital stay.
EFFECTIVE DATE: October 1, 2006, except for the self-insured governmental health plan provision and a technical change, which are effective upon passage.

Background
CONTESTED CASE HEARING TIMEFRAMES
Current law requires the commissioner to (1) hold a hearing within 20 days of receiving a request from a person or insurer aggrieved by an order or decision of hers and (2) render a decision within 15 days of the hearing. The law increases the timeframes to 30 days in which to hold a hearing and 45 days to issue a decision.

INVESTMENTS IN AFFILIATES
By law, and unchanged by the bill, an insurer may invest in one or more of its subsidiaries, subject to certain limitations and requirements. The bill allows an insurer to invest in its affiliates, subject to the same limitations and requirements that apply to investments in subsidiaries.
The law allows an insurer to invest in the common stock, preferred stock, debt obligations, or other securities of one or more of its affiliates in an amount up to the lesser of 10% of the insurer's assets or 50% of its surplus if, after the investment, the insurer's surplus is reasonable in relation to its outstanding liabilities and adequate for its financial needs.
Investments in domestic and out-of-state insurance company affiliates are not included in calculating the amount of the investments, but the following items must be:
1. the total amount spent and obligations assumed in the acquisition or formation of an affiliate, including organization expenses and contributions to capital and surplus and
2. all amounts spent in acquiring additional common or preferred stock, debt obligations, and other securities and contributions to the capital and surplus of an affiliate after its acquisition or formation.
Insurers may invest any amount in the common or preferred stock, debt obligations, and other securities of one or more affiliates engaged or exclusively organized to engage in the ownership and management of the insurer's investment, if the affiliate agrees to limit its investments so that

they will not cause the insurer's total investments to exceed the investment limitations specified. "Total investment of the insurer" includes (1) any direct investments made by the insurer in assets and (2) the insurer's proportionate share of an investment by an affiliate, which must be calculated by multiplying the amount of the affiliate's investment by the parent insurer's percentage ownership of it.

With the insurance commissioner's approval, an insurer may invest a greater amount in the common or preferred stock, debt obligations, or other securities of one or more affiliates if, after such investment, the insurer's surplus is reasonable in relation to its outstanding liabilities and adequate for its financial needs.

In determining an insurer's financial condition, its investments in affiliates must be valued using a method (1) approved by the commissioner and (2) consistent with procedures established by the National Association of Insurance Commissioners.

REQUEST FOR INFORMATION FOR APPEAL

By law, and unchanged by the bill, an insurer or MCO must provide the insurance commissioner, an enrollee, or a provider with certain appeal-related information within five business days of receiving a request. Failure to do so subjects the insurer or MCO to a fine of $ 100 for each day of violation. The information includes written verification that the plan is fully insured, self-insured, or otherwise funded.

If the plan is fully insured, current law requires the insurer or MCO to also send: (1) written certification to the commissioner or designated review entity that the benefit or service appealed is covered; (2) written certification that the policy or contract is accessible electronically, along with clear and simple instructions on how to access it; or (3) a copy of the entire policy or contract between the enrollee and the MCO. Under the bill, the insurer or MCO must also send this information if the plan is a self-insured governmental health plan. With respect to forwarding a copy of the contract, an insurer or MCO must notify the plan sponsor, who must send, or direct the insurer or MCO to send, the copy.

Under the bill, the MCO's failure to notify the plan sponsor within the five-business-day period or before the 30-day appeal period ends, whichever is later as determined by the commissioner, (1) creates a presumption that the benefit or service is a covered benefit for purposes of accepting the appeal for full review and (2) entitles the commissioner to require the MCO to reimburse the Insurance Department for appeal-related expenses. The presumption established does not create or authorize benefits or services exceeding those in the enrollee's policy or contract. By law, and unchanged by the bill, an insurer's or MCO's failure to provide information within the specified timeframes also creates the presumption and permits the commissioner to require the insurer or MCO to reimburse the department for appeal-related expenses.

UTILIZATION REVIEW APPEAL DECISION

Current law requires a utilization review company to have a licensed practitioner of the medical arts certify appeal determinations to not certify an admission, service, procedure, or extended hospital stay. The bill instead requires a licensed practitioner of the healing arts to certify the determination. Connecticut statutes define the practice of "healing arts" as the practice of medicine, chiropractic, podiatry, natureopathy, and optometry.

Public Act No. 06-117 (House Bill No. 5593)
An Act Concerning Requirements for the Filing of Annual Reports and Financial Statements by Insurers.
(Signed by the Governor 6/2/2006)

This act requires the insurance commissioner to keep confidential an actuary's or reserve specialist's workpapers, actuarial report, and actuarial opinion summary. It specifies that such documents are not subject to subpoena or disclosable under the Freedom of Information Act. Under current law, insurers and HMOs must file financial reports and an actuary's or reserve specialist's certification of reserve requirements with the commissioner. Regulations specify the contents and scope of the certification and require that workpapers be available to the commissioner.
EFFECTIVE DATE: October 1, 2006

Acts of Direct Interest to the Insurance Department

Property and Casualty

Public Act No. 06-104 (Senate Bill No. 410)
An Act Concerning Claims For Uninsured Or Underinsured Motorist Benefits And Insurance Rate Filing Requirements.
(Signed by the Governor 6/2/2006)

The bill:
1. permits insurers to file and use new rates for personal lines (e. g. , home, auto, marine, umbrella) without the insurance department's prior approval if they increase or decrease rates by no more than 6% under certain conditions;
2. requires a claimant for uninsured or underinsured motorist benefits (e. g. , following a car accident involving an uninsured or insufficiently insured vehicle) to make reasonable efforts to determine what liability coverage exists for the owner and operator of the alleged uninsured or underinsured vehicle; and
3. prohibits an automobile insurer from requiring a claimant, in order to be eligible for benefit payment, to provide affidavits or written statements from the owner or operator regarding his uninsured or underinsured status at the time of the accident.
EFFECTIVE DATE: October 1, 2006, except the property and casualty insurance rate provisions are effective July 1, 2006 until July 1, 2009.

Background
FILE AND USE 6% RATE BAND
The bill permits, from July 1, 2006 to July 1, 2009, property and casualty insurers to file new premium rates for personal lines with the Insurance Department and use them immediately without receiving prior approval if they result in a statewide rate increase or decrease of no more than 6% for all products included in the filing. The new rate cannot apply on an individual basis. The bill provides that an insurer may submit more than one rate filing using the 6% band to the department in any 12-month period if all rate filings submitted within the 12 months, in combination, do not result in a statewide rate change of plus or minus 6% for all products included in the filing.
An insurer can apply a rate increase within the 6% band only on or after a policy renewal and after notifying the insured. Rate filings requesting to increase or decrease rates by more than 6% must follow existing rate filing requirements (i. e. , insurers must receive approval from the Insurance Department before using such new rates).
Filing made pursuant to the 6% band requirements are deemed to comply with the existing rating laws, except that the commissioner is authorized to determine whether they are inadequate or unfairly discriminatory.
The bill requires the commissioner to order the insurer to stop using a rate change within the 6% band on a specified future date if she determines it is inadequate or unfairly discriminatory. The order must be in writing and detail why the rate is inadequate or unfairly discriminatory. If the order is issued more than 30 days after the filing is submitted to the department, it applies prospectively only and does not affect any contract issued before the order's effective date.

UNINSURED AND UNDERINSURED MOTORIST BENEFITS

The bill requires a person, when making a claim to his automobile insurance company for uninsured or underinsured motorist benefits, to make reasonable efforts to determine what liability coverage exists for the owner and the operator of the alleged uninsured or underinsured vehicle. For a motor vehicle accident occurring after September 30, 2006, the bill prohibits an insurance company from requiring a claimant, in order to be eligible for benefit payment, to provide affidavits or written statements from the owner or operator regarding their uninsured or underinsured status at the time of the accident.

The bill specifies that it does not "relieve any person seeking to secure any coverage under an automobile insurance policy of any duty or obligation imposed by contract or law. " (It is unclear what this provision means. It could mean that a person looking to purchase automobile insurance still must meet any contractual or legal duty. However, if he has not yet purchased coverage, it is not clear what contract or law he looks to for any duty or obligation owed. Alternatively, the provision could mean that a person seeking to use the coverage he has under an existing policy must look to the applicable contract and law for any imposed duty or obligation, in which case the contractual terms would supersede the bill; thus, an insurer could require, as a matter of contract, that an insured obtain written statements or affidavits from the owner and the operator of an alleged uninsured or underinsured vehicle regarding their insurance policies, if any.

Public Act No. 06-108 (House Bill No. 5371)
An Act Concerning Extended Reporting Period Coverage Under Medical Malpractice Insurance Policies
(Signed by the Governor 6/2/2006)

This act limits the circumstances under which insurers must provide certain medical malpractice insurance coverage at no cost to physicians, surgeons, advanced practice registered nurses, physician assistants, and hospitals. It does this by (1) eliminating the requirement that policies issued on a claims-made basis provide prior acts coverage under certain circumstances and (2) changing the conditions under which policies must provide unlimited extended reporting period coverage. A claims-made policy covers a claim filed during the policy period as long as the incident on which the claim is based occurred after the retroactive coverage date specified in the policy. If no retroactive date is identified, the policy covers injury or damage occurring prior to the policy effective date.

EFFECTIVE DATE: October 1, 2006; The act applies to policies renewed, delivered, or issued for delivery in Connecticut on or after October 1, 2006.

Background

PRIOR ACTS COVERAGE

The act removes the requirement that professional liability insurance policies issued on a claims-made basis provide prior acts coverage without additional charge to insureds under certain circumstances. Prior acts coverage insures against claims arising from acts that occurred before the beginning of a claims-made policy's coverage period.

Prior law required insurers to provide, at no additional cost, prior acts coverage if (1) the insurer stopped offering the policy in Connecticut for any reason and the insured was over age 55 and had been insured by the insurer for the seven consecutive years immediately preceding the

discontinuance or (2) the insured died, became permanently disabled and unable to carry out his practice, or retired permanently from practice.

UNLIMITED EXTENDED REPORTING PERIOD COVERAGE

The act requires professional liability insurance policies issued on a claims-made basis to provide extended reporting period coverage at no additional charge if, while an insured is covered under the policy, (1) the insurer stops offering policies in Connecticut because of a voluntary withdrawal from the state and (2) the insured is over age 60 or has been insured by the insurer for the five consecutive years immediately preceding the discontinuance. It requires the insurer to provide such coverage with equivalent terms and conditions and with an aggregate liability limit at least equal to the one specified in the policy. Extended reporting period coverage allows the insured to file claims after the claims-made policy otherwise terminates.

Under prior law, the coverage had to be provided when (1) the insurer stopped offering the policy in Connecticut for any reason and the insured was over age 55 and had been insured by the insurer for the seven consecutive years immediately preceding the discontinuance or (2) the insured died, became permanently disabled and unable to carry out his practice, or retired permanently from practice. By eliminating the requirement concerning disability and retirement, the act conforms to an existing Insurance Department regulation. The coverage had to be provided in the same manner as if the insurer continued offering the policy in Connecticut.

Related Laws

Connecticut 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 the claims were made (CGS § 38a-394).

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

Related Regulation

Under an Insurance Department regulation that 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)).

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 No. 06-109 (House Bill No. 5462)
An Act Concerning Transfer Of Insurance Policies To Affiliate Insurers
(Signed by the Governor 6/2/2006)

This act states that a property and casualty insurer, including a private passenger motor vehicle insurer, that transfers a policy to an affiliate insurer because of a merger or acquisition, does not require a policy cancellation or a cancellation notice to a policyholder if (1) there is no interruption of coverage and (2) the affiliate's policy contains the same terms, conditions, and provisions, including policy limits, as the transferred policy. By law, a property and casualty insurer must notify policyholders of the impending policy transfer to the affiliate at least 60 days before the transfer effective date.

Under the act, the affiliate (1) may apply its rates and rating plans when the policy renews and (2) must include in the policy renewal premium bill a notice that the policy was transferred from the other insurer. By law, the premium bill must be mailed or delivered to the insured at least 30 days before the policy renewal, except a bill does not have to be sent for (1) a commercial risk policy if the rate for the next policy year increases by less than 10% or (2) any policy that had an annual premium of less than $50,000 for the prior policy period.
EFFECTIVE DATE: October 1, 2006

Life and Health

Public Act No. 06-180 (House Bill No. 5372)
An Act Concerning Access To Imaging Services
(Signed by the Governor 6/7/2006)

This act limits the copayments that can be imposed on a person for all magnetic resonance imaging (MRI), computed axial tomography (CAT) scan, and positron emission tomography (PET) scan services performed in-network. It limits the copayments for MRIs and CAT scans to no more than (1) $375 for all such services annually and (2) $75 for each one. It limits the copayments for PET scans to no more than (1) $400 for all such scans annually and (2) $100 for each one.

These copayment limits do not apply (1) if the physician ordering the imaging service performs it or is in the same practice group as the physician who performs it and (2) to high deductible health plans designed to be compatible with federally qualified health savings accounts.
The act applies to health insurers, HMOs, hospital service corporations, medical service corporations, and fraternal benefit societies providing group or individual coverage for such imaging services.
EFFECTIVE DATE: October 1, 2006

Public Act No. 06-38 (Senate Bill No. 422)
An Act Concerning Health Insurance Coverage For Breast Cancer Screening
(Signed by the Governor 5/8/2006)

This act changes when health insurance policies must provide coverage for a comprehensive ultrasound screening of an entire breast or breasts for a woman. Under prior law, a policy had to provide coverage if a physician recommended the screening for a woman classified as category 2, 3, 4, or 5 on the American College of Radiology's Breast Imaging Reporting and Database System (BI-RADS) mammogram reading scale. The act instead requires coverage if (1) a mammogram shows heterogeneous or dense breast tissue based on BI-RADS or (2) a woman is considered at an increased breast cancer risk because of family history, her own prior breast cancer history, positive genetic testing, or other indications determined by her physician or advanced-practice registered nurse. By law, unchanged by the act, coverage for breast ultrasound screening is subject to any policy provisions applicable to other covered services and is in addition to coverage required for mammograms.

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, 2006

Related Law
Health insurance policies must provide coverage for mammograms at least equal to the following: one initial examination for women ages 35 to 39 and one examination every year for women age 40 and older. Coverage is subject to any policy provisions applicable to other covered services.

Public Act No. 06-131 (House Bill No. 5114)
An Act Concerning Developmental Needs Of Children And Youth With Cancer
(Signed by the Governor 6/6/2006)

This act requires individual and group health insurance policies to provide coverage for neuropsychological testing of children diagnosed with cancer after December 31, 1999. The mandate applies to plans delivered, issued for delivery, amended, renewed, or continued in the state on and after October 1, 2006. The act also requires the social services commissioner to amend the state's Medicaid and State Children's Health Insurance Program plans to provide this coverage under HUSKY A and B.

Under the act, insurers and the HUSKY plans must cover tests a licensed physician orders to assess the extent chemotherapy or radiation treatment has caused the child to have cognitive or developmental delays. They may not require prior authorization for the tests.

The law requires individual and group health insurance policies that cover dependents to do so through age 18 and up to age 23 if they are full-time students at an accredited school. HUSKY A and B cover children through age 18.
EFFECTIVE DATE: October 1, 2006, except the HUSKY provision, which is effective on passage.

Public Act No. 06-5 (Substitute Senate Bill No. 259)
An Act Prohibiting Discrimination In Life Insurance Based On Lawful Travel Destinations
(Signed by the Governor 4/21/2006)

This act limits a life insurer's ability to underwrite a policy based on a person's past or future travel to a lawful destination. Under the act, an insurer cannot, on the basis of an applicant's or insured's past or future lawful travel destination, (1) deny or refuse to accept a life insurance application; (2) charge different premiums or rates for a life insurance policy; or (3) cancel, restrict, terminate, or not renew a policy. However, the act allows an insurer to deny an application or charge a different premium or rate based on a person's specific lawful travel destination if the action is (1) based on sound actuarial principles or (2) related to actual or reasonably anticipated experience (e. g., the insurer can demonstrate that travel to the specific location poses an increased risk of death).
EFFECTIVE DATE: Upon passage

Public Act No. 06-90 (House Bill No. 5461)
An Act Concerning Preferred Provider Networks
(Signed by the Governor 5/30/2006)

This act excludes from the Connecticut insurance code's definition of a "preferred provider network" (PPN) private clinical laboratories licensed by the Department of Public Health whose primary payments for contracted or referred services are made to other licensed laboratories or for associated pathology services. By law, the insurance commissioner licenses and regulates PPNs. Consequently, the act excludes such laboratories from PPN requirements. (Section 577 of sHB 5820 eliminates "private" from the exclusion, thus applying the exclusion from the statute to all clinical laboratories that meet the criteria specified.)
Existing law also excludes from the PPN definition: (1) managed care organizations, (2) workers' compensation preferred provider organizations, and (3) independent practice associations and physician hospital associations whose primary function is to contract with insurers and provide services to providers.
EFFECTIVE DATE: Upon passage

Background
Preferred Provider Network
A PPN enters into contracts with health care providers who agree to deliver health care services to covered individuals in exchange for payment. The PPN pays health care claims, taking on the financial risk for the delivery of services.

Public Act No. 06-188 (Senate Bill No. 703)
An Act Concerning Social Services And Public Health Budget Implementation Provisions
(Signed by the Governor 5/26/2006)

The following three sections of PA 06-188 are relevant to the Connecticut Insurance Department

§ 33 — UTILIZATION REVIEW INFORMATION
This section adds mental health-related information to the information utilization review companies must annually file with the insurance commissioner. It requires them to report (1) the reason for utilization review requests related to, at a minimum, inpatient admission, service, procedure, and extension of inpatient or outpatient treatment; (2) the number of requests denied by type; and (3) whether a request was fully or partially denied. They must report this information separately and by category for fully insured health benefit plans and self-insured or self-funded employee health benefit plans.
EFFECTIVE DATE: October 1, 2006

§ 34 — MANAGED CARE REPORT CARDS
Current law requires the insurance commissioner, in consultation with the public health commissioner, to develop and annually distribute a consumer report card on managed care companies. This section requires the report card to contain information or measures about the percentage of enrollees who receive mental health services, the utilization of mental health and chemical dependency services, inpatient and outpatient admissions, discharge rates, and average lengths of stay. The data collection must be consistent with Health Plan Employer Data and Information Set measures.
EFFECTIVE DATE: October 1, 2006

§ 35 — NOTICE OF BENEFITS
This section requires the insurance commissioner to notify each insurance company, HMO, and other entity that provides individual or group health insurance plans of any benefits the law requires them to provide or any modifications in those benefits that occur on or after October 1, 2006. She must notify them in writing at least 30 days before the benefit or modification takes effect. She must also notify them in writing, before any benefit or modification takes effect or a plan is renewed, of necessary policy forms reflecting those benefits or modifications.
EFFECTIVE DATE: October 1, 2006

Human Resources – Agency Operations – Other

Public Act 06-132 (House Bill No. 5652)
An Act Concerning Public Agency Termination, Suspension Or Separation Agreements
(Signed by the Governor 6/6/2006)

This act makes confidentiality provisions in termination, suspension, and separation agreements between a public agency and an employee or personal services contractor subject to disclosure under the Freedom of Information Act. The act covers agreements that prohibit a public agency from disclosing the existence of the agreement or the cause or causes for a termination,

suspension, or separation, as applicable, including alleged or substantiated sexual abuse, sexual harassment, sexual exploitation, or sexual assault by the employee or contractor. Public agencies covered under the act are all state and local government agencies, departments, institutions, bureaus, boards, and commissions, including all executive, administrative, and legislative offices, and the administrative functions of the Judicial Branch and the Division of Criminal Justice.
EFFECTIVE DATE: October 1, 2006

Public Act 06-146 (Substitute Senate Bill No. 459)
An Act Concerning Accrued Leave for State Employees Serving in the Military
(Signed by the Governor 6/6/2006)

This act gives a state employee called to active military service in the National Guard or the military reserves vacation and sick leave accrual for the entire period of active service rather than just the first 30 days. It applies to an employee called to duty for (1) federal or state post-September 11 anti-terrorism or homeland security-related duty or (2) the Afghanistan or Iraq wars.

By law, unchanged by the act, a guard member or reservist accrues such time and receives full state pay during the first 30 days of active duty. By law, a state employee called to active duty receives partial state pay (to make up the difference, if any, between his military pay and his state pay) for any active service time beyond 30 days.
Prior law and the act cover state employees who are guard members in other states.
EFFECTIVE DATE: Upon passage

Public Act 06-62 (Substitute Senate Bill No. 314)
An Act Extending Federal Protections to State Service Members
(Signed by the Governor 5/19/2006)

This act gives to National Guard members whom the governor orders into state active service (e. g., riot control and disaster response) the same protections two federal laws give to service members in federal active service, except those pertaining to life insurance. The laws are the Uniformed Services Employment and Reemployment Rights Act (USERRA) and Servicemembers Civil Relief Act (SCRA).

USERRA provides reemployment rights and protections for members returning from serving in the armed forces. SCRA provides rights and protections to people in active-duty service.
EFFECTIVE DATE: October 1, 2006

Public Act 06-102 (Substitute House Bill No. 5011)
An Act Concerning Family And Medical Leave For State Employees
(Signed by the Governor 6/2/2006)

The following section of PA 06-102 is relevant to the Connecticut Insurance Department

FAMILY LEAVE FOR STATE EMPLOYEES
The act allows state employees to take up to 24 weeks of unpaid leave over a two-year period to care for seriously ill:
1. foster, adopted, and step-children;
2. children under their guardianship; and
3. those for whom they stand *in loco* parentis (in place of a parent).
Prior law did not authorize leave for ill non-biological children.

The act also specifies that leave can be taken to care for a child (1) under age 18 or (2) over age 18 if he is incapable of caring for himself because of a mental or physical disability.
EFFECTIVE DATE: October 1, 2006

Public Act 06-113 (House Bill No. 5495)
An Act Concerning Assessments For Immunizations
(Signed by the Governor 6/2/2006)

This act removes the cap on the amount each Connecticut insurance company and HMO must pay for immunization services that the Department of Public Health provides. Prior law capped the amount paid by any one company at 25% of the expenditures of the Insurance Department and the Office of the Healthcare Advocate. Under the act, each company pays a proportionate share of the total due from all insurers and HMOs. That proportion is based on the company's share of total premium taxes and other charges the state imposes on all insurers and HMOs for business conducted in Connecticut during the previous calendar year. The fee is deposited in the General Fund.
EFFECTIVE DATE: July 1, 2006

Public Act 06-32 (House Bill No. 5738)
An Act Concerning Reconsidered Agency Decisions and Appeals Under the Uniform Administrative Procedure Act
(Signed by the Governor 5/8/2006)

This act caps, at 90 days, the maximum time a state agency has to issue a new decision in a contested case it decides to reconsider. By law, agencies can decide to reconsider a final decision in a contested case on their own or pursuant to a petition from a party to the case. With one exception, the act provides that a decision an agency issues in a contested case on reconsideration replaces its original decision as the final decision from which an appeal may be taken. The exception applies if an agency fails to render a decision on reconsideration within the 90-day period the act establishes. In this case, the original decision is the final decision for purpose of an appeal. By law, an appeal may be based on a number of issues, including issues the agency (1) decided in its original final decision that were not the subject of the reconsideration; (2) was requested, but declined, to address on reconsideration; and (3) reconsidered but did not modify.

Lastly, the act establishes a deadline for filing an appeal after a petition for reconsideration is filed. The deadline is 45 days after (1) the petition is denied, (2) a decision made after reconsideration is mailed or personally delivered, or (3) the 90-day deadline for the decision. *EFFECTIVE DATE: October 1, 2006*

Other Acts of Interest

Property and Casualty

Public Act 06-173 (Substitute House Bill No. 5839)
An Act Concerning Blood Or Breath Tests Of Surviving Operators Involved In Motor Vehicle Accidents And Prohibiting Persons Facilitating Illegal Street Racing
(Signed by the Governor 6/9/2006)

This act broadens the circumstances where a surviving driver of a car accident involving serious physical injury or death must give a blood or breath sample. The bill requires the driver to give a sample if the police (1) charge him with a motor vehicle violation regarding the accident and (2) have a reasonable articulable suspicion that he was driving while under the influence of liquor or drugs. Under current law, unchanged by the bill, the police can require a test from a surviving driver if the officer has probable cause to believe that the driver was driving under the influence.

The law prohibits driving a motor vehicle on a public highway for purposes of betting, racing, or making a speed record. The bill additionally prohibits (1) possessing a motor vehicle under circumstances showing an intent to use it in a prohibited race or event, (2) acting as a starter, timekeeper, judge, or spectator at such a race or event, or (3) betting on the race's or event's outcome. It subjects this conduct to the penalties in current law for driving in these races or events: (1) a first offense is punishable by up to one year in prison, a fine of $ 75 to $ 600, or both and (2) subsequent offenses are punishable by up to one year in prison, a fine of $ 100 to $ 1,000, or both.
EFFECTIVE DATE: October 1, 2006

Public Act 06-195 (Substitute Senate Bill No. 317)
An Act Concerning Revisions to Department of Public Health Statutes
(Signed by the Governor 6/7/2006)

This bill makes numerous substantive and technical changes to Department of Public Health (DPH) and other related statutes concerning various health care professionals, health care facilities, programs, and activities.

The following sections of PA 06-195 are of interest to the Connecticut Insurance Department

Section 17 of this act gives the Department of Public Health access to records maintained by insurance companies for review during the course of an investigation of a health care practitioner.
EFFECTIVE DATE: October 1, 2006

Section 20 of this act requires dentists who provide direct patient care services to maintain professional liability insurance or other indemnity against liability for professional malpractice of at least $ 500,000 per person, per occurrence, with an aggregate of at least $ 1. 5 million. A dentist insured by a claims-made policy does not lose the right to unlimited additional extended

reporting period coverage when he permanently retires from practice if he solely provides professional services without charge at a tax-exempt clinic. Each insurance company issuing such policies must annually provide the Department of Public Health with information on policies cancelled or not renewed in the preceding calendar year.
EFFECTIVE DATE: October 1, 2006

Sections 83 and 85 of this act requires licensed physical therapists who provide direct patient care to maintain professional liability insurance or other indemnity against liability for professional malpractice of at least $ 500,000 per person, per occurrence, with an aggregate of at least $ 1. 5 million. Each insurance company issuing such policies must annually provide the Department of Public Health with information on policies cancelled or not renewed in the preceding calendar year.
EFFECTIVE DATE: October 1, 2006

Life and Health

Public Act 06-178 (House Bill No. 5189)
An Act Requiring The Disclosure Of Fee Information By Health Insurers
(Signed by the Governor 6/9/2006)

This act requires each contracting health organization (managed care organization (MCO) or preferred provider network) to implement a procedure by October 1, 2007 under which a contracted physician, physician group, or physician organization may view the fee schedule that determines the payment amount for the most commonly performed and billed services. It also requires the chairpersons and ranking members of the Insurance Committee to meet at least twice a year with physicians and MCOs to discuss issues regarding their contracts, including any national settlement agreements arising from recent lawsuits by physicians against MCOs, to the extent permitted by the agreements.
EFFECTIVE DATE: October 1, 2006

Background
FEE INFORMATION
This act requires each contracting health organization (CHO), by October 1, 2007, to establish and implement a procedure that allows a contracted physician, physician group, or physician organization to confidentially view the fee schedule the CHO pays for the 50 current procedural terminology (CPT) codes the physician or his group most commonly performs. The procedure must also permit a contracted physician, physician group, or physician organization to request to view the CPT codes he actually bills or intends to bill, as long as they are within the physician's specialty or subspecialty. The procedure requirement only applies to a physician, physician group, or physician organization whose services the CHO reimburses based on CPT codes. Under the act, the CHO must present the fee information in a digital format or by electronic means. The act makes the information proprietary and confidential and permits the CHO's procedure to include penalties, including terminating a physician, physician group, or physician organization from its provider network, for unauthorized disclosure of the fee information.

"Physician" includes a physician, surgeon, chiropractor, podiatrist, psychologist, and optometrist.

Public Act 06-123 (Senate Bill No. 16)
An Act Protecting Municipal Retiree Health Insurance Benefits
(Signed by the Governor 6/2/2006)

This act bars municipalities, housing authorities, and other municipal subdivisions from eliminating or reducing group health insurance benefits to municipal retirees in violation of a union contract. It applies to municipalities that arrange for health insurance on their own or through the state-sponsored Municipal Employee Health Insurance Program. Prior law did not specifically address municipalities providing health insurance for their retirees. But by law, a municipality cannot reduce retiree pension benefits.

The act specifically applies to SA 01-1, which created the Waterbury Financial Planning and Assistance Board and gave the board broad power over the city's finances, budgets, and union contracts.
EFFECTIVE DATE: Upon passage

Background
ALTERNATIVE CARRIER OPTION AND COLLECTIVE BARGAINING EXCEPTION TO THE OPTION
Although the act bars municipalities and other subdivisions from eliminating or diminishing retiree group health insurance benefits in violation of a union contract, it specifically allows them to select an alternative group health insurance carrier for retirees if the benefits remain at least equivalent to those previously provided. But it prohibits the option to seek a new carrier in cases (1) where the retiree's health benefits are provided through a union contract negotiated under the Municipal Employee Relations Act (MERA) and the contract is in effect on the date of the person's retirement and (2) the contract contains a provision specifying that retirees are entitled to the same health insurance benefits provided to active employees under the same contract.

Public Act 06-125 (Substitute Senate Bill No. 164)
An Act Concerning Patient Access to Physical Therapy
(Signed by the Governor 6/2/2006)

This act allows physical therapists meeting certain standards to treat patients without referral from another health care practitioner, except in cases involving workers' compensation injuries and a specific kind of treatment. The act establishes procedures a physical therapist must follow in treating patients without a referral.

The act specifically authorizes the Board of Examiners for Physical Therapists to take disciplinary action, including license suspension or revocation, against a physical therapist who fails to comply with continuing education requirements. The law already subjected physical therapists to disciplinary action for failure to comply. And the act modifies the process for therapists to seek a waiver from continuing education requirements.

It specifies that physical therapy does not include performing surgery; prescribing drugs; or diagnosing disease, injury, or illness. And it prohibits physical therapists and physical therapist assistants from using the terms "chiropractic adjustment or manipulation" to indicate or suggest they use these techniques in their practice.
EFFECTIVE DATE: October 1, 2006

Public Act 06-142 (Substitute Senate Bill No. 160)
An Act Concerning Hospital Acquired Infections
(Signed by the Governor 6/6/2006)

This act creates an 11-member "Committee on Healthcare Associated Infections" responsible for developing, operating, and monitoring a mandatory reporting system for healthcare associated infections. The act defines a "healthcare associated infection" as any localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent or its toxin that (1) occurs in a patient in a healthcare setting; (2) was not found present or incubating at the time of admission unless the infection was related to a previous admission to the same setting; and (3) if the setting is a hospital, meets the criteria for a specific infection site, as defined by the National Centers for Disease Control.

The act requires the Department of Public Health (DPH) to implement the committee's recommendations concerning a mandatory reporting system for infections and standardized data reporting measures. It also establishes reporting requirements.
EFFECTIVE DATE: Upon passage

COMMITTEE MEMBERSHIP
The committee includes the DPH commissioner or his designee and the following 10 members appointed by him: (1) two representing the Connecticut Hospital Association; (2) two from organizations representing health care consumers; (3) two who are either hospital-based infection disease specialists or epidemiologists with demonstrated knowledge and competence in infection disease issues, (4) one representative of the Connecticut State Medical Society, (5) one representative of a labor organization representing hospital-based nurses, and (6) two public members. All appointments must be made by August 1, 2006 and the first meeting must be held by September 1, 2006.

Public Act 06-170 (House Bill No. 5639)
An Act Concerning The Establishment of a Council to Advise the Commissioner of Social Services on Matters Relating to the Implementation and Operation of the Medicare Part D Program
(Signed by the Governor 6/6/2006)

This act creates a 22-member council to advise the Department of Social Services (DSS) commissioner on matters relating to the administration and implementation of the federal Medicare Part D program, which began January 1, 2006 and helps Medicare beneficiaries pay for their prescription drugs. The council (1) must make legislative recommendations to the General

Assembly about Medicare Part D administration by DSS; (2) may make federal legislative recommendations about Part D to members of the state's congressional delegation; and (3) must report annually to the Human Services, Public Health, and Aging committees, beginning January 15, 2007.
EFFECTIVE DATE: Upon passage

Public Act 06-39 (Substitute Senate Bill No. 425)
An Act Ensuring Payment for Health Care Services Rendered to Connecticut Residents with an Elevated Blood Alcohol Content
(Signed by the Governor 5/2/2006)

This act prohibits health insurance policies from denying coverage for health care services rendered to an injured insured person if the injury is alleged to have occurred or occurs when the person has an elevated blood alcohol content (BAC) level or is under the influence of intoxicating liquor, any drug, or both. The act defines an "elevated BAC" as 0. 08% or more. (The act does not define "under the influence" or specify who makes that determination.)

The act applies to individual and group health insurance policies delivered, issued, amended, renewed, or continued on or after October 1, 2006 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, 2006

Human Resources - Agency Operations - Other

Public Act 06-59 (House Bill No. 5677)
An Act Concerning Surety Bonds and Construction Contracts
(Signed by the Governor 5/8/2006)

The law requires public works contracts for which a payment bond is required to include certain provisions establishing a payment schedule. This act requires a general contractor or subcontractor, regardless of whether a surety bond is in place, to deposit funds in an interest-bearing escrow account on the written demand of its subcontractor if (1) a payment is not made according to the contract schedule, (2) 10 days have passed since the payment date, and (3) the subcontractor has sent a payment demand by registered or certified mail. Under prior law, the general contractor or subcontractor had to escrow funds under these conditions only if a surety bond was not in place. By law, unchanged by the act, the escrowed amount must be for the amount that the general contractor or subcontractor is liable, which is the amount of the claim plus 1% per month interest. The contractor or subcontractor may refuse to escrow funds if he contends that his subcontractor has not substantially completed the work according to the terms of the contract.
EFFECTIVE DATE: October 1, 2006

Public Act 06-78 (Senate Bill No. 493)
An Act Concerning Subcontractor Claims
(Submitted to Secretary of State 5/17/06)

This act revises a subcontractor's or supplier's deadlines for filing payment claims against a general contractor's surety company under certain public works contracts and for suing a surety company to compel payment.

The law requires public works contracts valued at more than $50,000 to require the general contractor to (1) pay the amount due subcontractors or suppliers within 30 days after being paid by the state or municipality if the work performed or material supplied was included in a requisition or estimate and (2) include in its subcontracts a requirement that a subcontractor pay its subcontractors within 30 days after being paid by the general contractor. These contracts must also require the contractor to furnish a payment bond from a surety company. A general contractor or subcontractor who has not been fully paid after 60 days has the right to file a payment claim with the surety company.

Under prior law, the deadline for filing these claims was 180 days after the requisition for work or materials was submitted or, if the work or materials was not included in a requisition or estimate, 180 days after the work was performed or the materials supplied. The act instead makes the deadline for filing claims, other than for retainage, 180 days after the last date the claimant performed work or supplied materials. For retainage, the act sets 180 days after the payment due date as the deadline.

“Retainage” is the amount withheld from progress payments conditioned on substantial or final completion of all work in accordance with a construction contract, but it does not include amounts withheld for failure to comply with construction plans or specifications.

The act changes the deadline for filing a suit to enforce a claim in the same way that it changes the deadline for making a claim against the surety. Prior law required a suit to be filed within one year after the requisition was submitted or, if the work or materials was not included in a requisition, within one year after the work was performed or the material was supplied. The act instead makes the deadlines one year after the last date that the claimant performed work or supplied materials or, if the suit is being filed solely for payment of retainage, one year after the payment due date.
EFFECTIVE DATE: Upon passage

Public Act 06-140 (House Bill No. 5212)
An Act Concerning Freedom of the Press
(Signed by the Governor 6/6/2006)

With some exceptions, this act prohibits judicial, executive, and legislative bodies with the power to issue subpoenas or compulsory process from compelling the news media to testify about, produce, or disclose (1) information obtained or received, whether in confidence or not, in gathering, receiving, or processing information for potential communication to the public; (2) the identity of the information's source; or (3) information tending to identify the source. The

exception is for information (1) necessary to a pending criminal investigation or prosecution or a civil action; (2) not otherwise available; and (3) of interest to the public.

The act also provides that it cannot be construed to deny or infringe an accused's U. S. and state constitutional rights, in criminal prosecution, to use subpoenas to obtain witnesses in his behalf. The act makes information and the identity of a source obtained in violation of the act inadmissible in any action, proceeding, or hearing before a judicial, executive, or legislative body.

The act also requires any person or entity seeking information that is not protected from disclosure to pay the news media's actual copying costs in providing the information and prohibits using subpoenas to avoid paying.
EFFECTIVE DATE: October 1, 2006

Public Act 06-84 (Substitute Senate Bill No. 25)
An Act Concerning Social Security Offsets Under the Workers' Compensation Act
(Signed by the Governor 5/30/2006)

This act eliminates the requirement that workers' compensation wage replacement benefits be reduced by an amount equal to the Social Security retirement benefits to which the injured worker is entitled. Under prior law, a person receiving Social Security retirement benefits who is eligible for workers' compensation total disability payments for an injury that took place on or after July 1, 1993, receives workers' compensation only if the compensation exceeds his Social Security benefit, and he receives only the amount of compensation in excess of his Social Security. Under the act, the injured worker can receive both Social Security and workers' compensation benefits with no reduction for any compensable injury that occurs on or after the act's effective date (May 30, 2006).
Workers' compensation total disability benefits are payable to workers who cannot work because of a job-related injury or illness. Social Security retirement benefits are payable to eligible retirees once they reach age 62.
EFFECTIVE DATE: Upon passage

Public Act 06-106 (Senate Bill No. 537)
An Act Concerning Remission to Municipalities of a Surcharge for Certain Motor Vehicle Violations
(Signed by the Governor 6/2/2006)

This act adds a $10 surcharge on specified motor vehicle violations and requires the state to remit the revenue to the municipalities where the violations occurred. The surcharge applies to anyone who pays a fine or forfeiture for any of 35 motor vehicle violations, including: (1) speeding, (2) reckless driving, (3) driving under the influence, (4) making an illegal turn, (5) failing to yield right of way, (6) failing to stop for a school bus (for a first offense), and (7) failing to stop at a stop sign. The surcharge also applies to anyone who pays a fine or forfeiture under any ordinance enacted in accordance with these laws. The act requires the Superior Court clerk or the chief court administrator (or his designee) to certify to the comptroller the amount

due for the previous quarter to each municipality. The certifications must be made by January 30, April 30, July 30, and October 30, of each year.
EFFECTIVE DATE: July 1, 2006

Public Act 06-40 (Substitute Senate Bill No. 593)
An Act Concerning the Applicability of Offers of Judgement and the Inadmissibility of Apologies made by Health Care Providers
(Signed by the Governor 5/8/2006)

This act specifies that the offer of judgment law that was in effect on September 30, 2005 applies to any cause of action accruing before October 1, 2005. The offer of compromise law, which replaced the offer of judgment law on October 1, 2005, applies to any cause of action that accrues on or after October 1, 2005. In general, a cause of action accrues when the right to file a lawsuit on a claim is complete. PA 05-275, which became effective October 1, 2005, changed the "offer of judgment" law in several ways, including changing the terminology to "offer of compromise" and ending the process in a withdrawal of the lawsuit after payment, instead of after a judgment against the defendant. PA 05-275 also reduces the interest rate the court may award with respect to an offer of compromise for cases that accrue after September 30, 2005, from 12% to 8%, and established some additional requirements for such cases.

The law makes expressions of sympathy by employees of health care providers and institutions inadmissible in medical malpractice lawsuits or related arbitration proceedings by victims of unanticipated outcomes of medical care. The act specifies that this applies to employees of state-operated health care institutions or facilities.
EFFECTIVE DATE: Upon passage

Public Act 06-186 (House Bill No. 5845)
An Act Making Adjustments for the Biennium Ending June 30, 2007
(Signed by the Governor 5/7/06)

The following sections of PA 06-186 may be of interest to the Connecticut Insurance Department

TAX CREDITS AGAINST INSURANCE PREMIUM TAX
Housing Tax Credit
This act increases the amount of tax credits available under, and expands the scope of, the state Rental Housing Assistance Trust Fund Program (popularly known as the Housing Tax Credit Program). Under this program, the Connecticut Housing Finance Authority (CHFA) allocates tax credits to businesses that contribute funds to nonprofit housing organizations developing low- and moderate-income housing.

Businesses eligible for these tax credits are insurance companies, hospitals, medical services corporations, air carriers, railroad companies, cable and community antenna companies, utility companies, and any business that pays the corporation tax.
EFFECTIVE DATE: July 1, 2006 and applicable to income years starting on or after January 1, 2006.

Job Creation Tax Credit
This act establishes a credit against the insurance premium, corporation, or utility company tax for companies that (1) relocate to Connecticut; (2) create at least 50 new, full-time jobs here; and (3) hire new employees for those jobs and keep them employed for at least 12 months. The credit equals up to 25% of the state income tax withheld from the new employees' wages. For each new employee, the credit applies for five consecutive years. The act limits the annual credits for all companies awarded in any one fiscal year to $ 10 million. Credits must be taken in the same income year as they are earned. Unused credits expire.

Companies must apply to the Department of Economic and Community Development commissioner for the credits. The commissioner may approve full or partial credits only if the proposed company relocation (1) is not economically viable without the credits and (2) provides a net benefit to economic development and employment in the state.
EFFECTIVE DATE: July 1, 2006 and applicable to income years starting on or after January 1, 2006.

Displaced Worker Tax Credit
This act gives a $ 1,500-per-worker business tax credit to companies that, on or after January 1, 2006, hire workers who (1) were employed in Connecticut and (2) were let go by a previous employer as direct result of a business restructuring in which at least 10 Connecticut workers were terminated by the same employer. To receive a credit, the new employer must (1) pay the workers at least 75% of their previous annual wages or salary for the first 12 months of employment, (2) not have been a related party to the old employer at the time of termination, and (3) not claim both the act's credit and the existing credit for hiring a displaced electrical worker for the same worker.

The credit applies against the insurance premium, corporation, and utility company taxes. It is allowed for the income year during which the displaced worker completes his first 12 months of employment with the taxpayer. The credit cannot exceed the total tax due and the act allows only one credit per qualifying worker.
EFFECTIVE DATE: July 1, 2006 and applicable to income years starting on or after January 1, 2006.

Historic Structures Tax Credit
This act authorizes $ 15 million a year in business tax credits for funds spent rehabilitating historic commercial and industrial properties for residential use. Property owners may apply for and claim the credits, which may equal up to 25% of the qualified rehabilitation costs, up to $ 2. 7 million. Owners can claim the credits or assign them to other parties.
EFFECTIVE DATE: July 1, 2006 and applicable to income years starting on or after January 1, 2006.

Donating Computers to Private Schools
This act extends an existing business tax credit for businesses that donate new or used computers to public schools to cover computer donations to private schools. By law, the maximum credit is 50% of the computer's fair market value when donated. Used computers may be no more than

two years old. The credit applies against the corporation tax and the insurance premium, air carrier, railroad company, cable and satellite TV, and utility company taxes.
EFFECTIVE DATE: July 1, 2006 and applicable to income years starting on or after January 1, 2006.