July 1, 2014

Mr. John Smith
CT Domestic Insurance Company
123 Insurance Ave
Hartford, CT 12345

Re: Childhood Immunization Vaccine Assessment

This letter will serve as your notification that your entity is subject to the Childhood Immunization Vaccine Assessment.

Conn. Gen. Stat. §19a-7j requires each affected domestic insurer, health care center ("HCC"), third party administrator ("TPA") as defined in Conn. Gen. Stat. §38a-720(11), and exempt insurer as defined in Conn. Gen. Stat. §19a-7j(b) to annually report by September 1st to the Insurance Commissioner the number of insured or enrolled lives in Connecticut as of the immediately preceding May 1st for which they are providing health insurance or administering a self-insured health benefit plan that provides coverage of the types specified in subdivisions (1), (2), (4), (11) and (12) of Conn. Gen. Stat. §38a-469[1]. Lives enrolled in (1) Medicare, (2) Department of Social Services medical assistance programs, (3) workers' compensation insurance, or (4) Medicare Part C plans are exempted from this report. The report should be submitted using the enclosed form completed in accordance with the instructions.

By November 1 of each year the Commissioner is required to determine each entity's assessment for the following year. Pursuant to Conn. Gen. Stat. §19a-7j, the Commissioner must calculate the assessment by multiplying the number of reported lives by a factor he determines annually to fully fund the program's appropriation as identified by the Office of Policy and Management annually in consultation with the Department of Public Health. For fiscal year 2015 the appropriation is $31,509,441. The factor will be determined by dividing $31,509,441 by the total number of reported lives from all entities to get a per life amount needed to fully fund the appropriation.

By December 1 of each year, the Commissioner must provide each assessed entity with notice of its proposed assessment and **the assessed entity will have 22 calendar days to appeal the proposed assessment. All assessment appeals must be received no later than December 22. This will be the only opportunity to appeal the proposed assessment. If any entity's life count changes (gains or losses), the per life factor will change for all assessed entities.**

[1] Sec. 38a-469. Definitions**.** As used in this title, unless the context otherwise requires or a different meaning is specifically prescribed, "health insurance" policy means insurance providing benefits due to illness or injury, resulting in loss of life, loss of earnings, or expenses incurred, and includes the following types of coverage: (1) Basic hospital expense coverage; (2) basic medical-surgical expense coverage; (3) hospital confinement indemnity coverage; (4) major medical expense coverage; (5) disability income protection coverage; (6) accident only coverage; (7) long term care coverage; (8) specified accident coverage; (9) Medicare supplement coverage; (10) limited benefit health coverage; (11) hospital or medical service plan contract; (12) hospital and medical coverage provided to subscribers of a health care center; (13) specified disease coverage; (14) TriCare supplement coverage; (15) travel health coverage; and (16) single service ancillary health coverage, including, but not limited to, dental, vision or prescription drug coverage.

Entities seeking to appeal should file amended reporting forms to the Insurance Department ("Department"). Appeals should state clearly the reason for reconsideration and should be signed and certified by an executive officer of the entity. The Department reserves the right to request materials and records to validate the appeal claims. Appeals received after the close of business December 22 will not be accepted for consideration by the Department and will need to be directed to Superior Court. If the aggregate count of covered lives does change as a result of appeals that may be submitted, a revised per life assessment factor will be recalculated which could affect your previously calculated assessed amount.

The Insurance Department will issue the **final assessment invoice by January 1** and the assessment must be paid annually to the Insurance Department by the following February 1.

To recap the timeline, by:

- September 1 – all entities report to Insurance Department number of Connecticut lives for the stated health lines
- November 1 – Commissioner must have determined assessment factor based on appropriation
- December 1 – Commissioner must have issued assessment statement to each affected entity
- **December 1-December 22 – assessed entity appeal period**
- February 1 (of the following year) – all entities must have paid assessment to Insurance Department

Any individual or entity that fails to file the September report must pay a late filing fee of $ 100 per day. The Insurance Commissioner may require anyone to produce records in their possession that were used to prepare the report for examination by the Commissioner or his designee. If the Commissioner determines there is discrepancy between the actual and reported number of insured or enrolled lives that was not made in good faith, the individual or entity must pay a civil penalty of up to $15,000 for each report filed with such a discrepancy.

Any entity aggrieved by the assessment can appeal to Superior Court.

If you have any questions, please do not hesitate to contact me at peter.zelez@ct.gov

Respectfully yours,

Peter W. Zelez
Fiscal Administrative Manager