



**CONNECTICUT
INSURANCE
DEPARTMENT
LEGISLATIVE SUMMARY**

2012

Connecticut Insurance Department

2011 Legislative Summary

Forward

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. The public acts referenced within this report were enacted during the 2012 regular session and the 2012 June Special Session of the Connecticut General Assembly. *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 12-103 (Senate Bill 411)

An Act Concerning the Insurance Holding Company System Regulatory Act

(Signed by the Governor 6/4/2012)

This act expands the scope of the Insurance Department's review when a domestic (Connecticut) insurance company is the subject of a proposed acquisition or other change of control. The act requires, in most cases, a party seeking to acquire the company to file a pre-acquisition notification with the insurance commissioner. It establishes a waiting period after the acquiring party files this notification.

The act expands the information that must be included on the application required by law for the department's review of these transactions. It makes changes in the procedures for reviewing these transactions and the criteria the commissioner must use in determining whether to approve a transaction. The act requires the commissioner to evaluate whether the proposed acquisition will (1) substantially reduce competition in any insurance line in the state or (2) tend to create a monopoly in the state. In making this evaluation, he must consider the percentages of market share the involved insurers possess and the markets where they compete. The act allows the commissioner to issue orders in connection with such proposed transactions and impose civil penalties and other sanctions if they are violated.

The act requires any person controlling a domestic insurance company that seeks to divest its controlling interest to file a confidential notice of the proposed divestiture with the commissioner and send it to the company at least 30 days before divesting. It requires the commissioner to adopt regulations governing when his prior approval is required for a divestiture.

The act expands confidentiality requirements for information provided to the department under related provisions of existing law.

It expands filing requirements for insurance companies that are part of holding company systems (i.e., two or more affiliated persons, at least one of which is an insurance company) by requiring, in certain cases, the person who ultimately controls an insurance company to file an annual enterprise risk report with the commissioner. This risk includes any circumstances involving one or more affiliates of an insurer that may harm its financial condition or liquidity or that of its

holding company system. It subjects certain transactions between insurers and their holding company systems to department review and approval.

The act allows the commissioner to initiate, be a member of, or participate in a supervisory college. This is a temporary or permanent forum for communication between and cooperation among state, federal, and international regulatory officials.

The act allows the commissioner to examine an insurance company or its affiliates to determine the company's financial condition, including its enterprise risk.

Under the act, the commissioner may, rather than must, require a domestic insurance company that has been acquired to submit to a financial examination and a market conduct examination within 30 days after the acquisition.

The act makes technical and conforming changes.

EFFECTIVE DATE: October 1, 2012; PA 12-2 June 12 Special Session advances the effective date of the supervisory college provisions to July 1, 2012.

CHANGE OF CONTROL OF AN INSURANCE COMPANY (Section 2)

By law, (1) no person other than a securities issuer may engage in activities to acquire control of a domestic insurance company or, in most cases, a corporation controlling such a company and (2) no person may enter into an agreement to merge with or otherwise acquire control of a domestic insurance company or a corporation controlling the company unless he or she meets certain conditions. Such a person must notify the Insurance Department before it completes the transaction and must (1) file an application with the insurance commissioner containing the information required by law, (2) send this information to the company, and (3) obtain the commissioner's approval of the application. By law, there is a rebuttable presumption that one entity controls another when it owns or controls at least 10% of its voting shares.

Under prior law, "person" included individuals and various types of business entities. The act excludes from the definition of "person," and thus the above provisions, a securities broker normally holding less than 20% of the voting securities of an insurance company or an entity that controls an insurance company.

The act specifies that a "domestic insurance company" includes any person controlling such a company, unless it is directly or through affiliates primarily engaged in business other than insurance, as determined by the commissioner. In doing so, it extends to persons controlling insurance companies, such as holding company systems, the law's provisions governing the acquisition of a controlling interest in an insurer that already applied to the insurers themselves. For example, if a holding company controlled an insurer, a person seeking control over the holding company would need to comply with the law's provisions.

PRE-ACQUISITION NOTIFICATION AND REVIEW (Sections 2 and 3)

Notification

The act requires, in most cases, a party seeking to acquire an insurance company to file a pre-acquisition notification with the commissioner. It also allows the acquired party to file this

notification. Under the act, an acquisition includes any agreement, arrangement, or activity that will result in a person acquiring, directly or indirectly, the control of another through (1) the acquisition of voting securities, assets, or bulk reinsurance or (2) a merger. The commissioner must treat any filed information as confidential.

The notification must be in a form and contain information as the National Association of Insurance Commissioners (NAIC) prescribes. The Connecticut commissioner may require additional material and information he considers necessary. This can include, among other things, the opinion of an economist on the proposed acquisition's effect on competition in this state that permits the commissioner to evaluate whether it will violate the competitive standard established by the act.

The notification requirements do not apply to a purchase of securities solely for investment purposes, so long as they are not used (by voting or otherwise) to cause or attempt to cause substantial reduction of competition in any Connecticut insurance market. If a purchase of securities results in the purchaser gaining control of at least 10% of the shares of the acquired company, it is not considered to be solely for investment purposes unless (1) the insurance regulatory official of the insurance company's state of domicile accepts a disclaimer of control from the company or affirmatively finds that control does not exist and (2) the official communicates this to the Connecticut commissioner.

The requirements also do not apply to the acquisition:

1. of a person by another person when neither is directly or through affiliates primarily engaged in the business of insurance;
2. of an affiliate;
3. if (a) the combined market share of the involved insurers will not exceed 5% of the total market in any market, (b) there will be no increase in any market share, or (c) the combined market share of the involved insurers will not exceed 12% of the total market in any market and the market share will not increase by more than 2% of the total market in any market;
4. when notification would be required solely due to the resulting effect on Connecticut's ocean marine insurance business; or
5. of an insurance company when the insurance regulatory official of its state of domicile affirmatively determines that it is failing and (a) there is no feasible alternative to improving its condition, (b) the public benefits of improving the company's condition through the acquisition exceed the public benefits that would arise from not reducing competition in Connecticut, and (c) the official has communicated this to Connecticut's commissioner.

Under the act, an “involved insurer” is (1) an insurance company that acquires or is acquired by another person, (2) an affiliate of the acquiring or acquired company, or (3) the insurance company that results from the merger.

Waiting Period

The act creates a waiting period once the acquiring party files the notification. The waiting period begins the date the commissioner receives the notification and ends 30 days later, unless the commissioner ends it earlier. During this period, the commissioner may require, on a one-time basis, the acquiring or the acquired party to submit additional information relevant to the

proposed acquisition. In this case, the waiting period ends on the 30th day after the commissioner receives the additional information or ends the waiting period, whichever is earlier.

Insurance Department Review

The commissioner must evaluate a proposed acquisition that is subject to the notification requirement to determine whether it will (1) substantially reduce competition in any line of insurance business in this state or (2) tend to create a monopoly in this state. In making his evaluation, the commissioner must consider the percentages of market share the involved insurers possess and the market in which they compete.

Under the act, for acquisitions involving more than two involved insurers, there is prima facie evidence of a violation of the act's competitive standards if a comparison of the percentage of market share of the involved insurance company with the largest market share (Insurer A), against any other involved insurer (Insurer B) shows for any comparison that the percentages exceed those in the tables described below. If a percentage is not shown in the tables, it must be interpolated.

Highly Concentrated Markets. For highly concentrated markets (those where the four largest insurance companies have 75% or more of the market), the shares are:

	Insurer A	Insurer B
Market Share	4%	4% or more
	10%	2% or more
	15%	1% or more

Thus, if the largest of three companies involved in a transaction has a 10% market share and the next largest has a 5% share, there would be a presumption that the transaction is anticompetitive.

Other Markets. In other markets, the shares are:

	Insurer A	Insurer B
Market Share	5%	5% or more
	10%	4% or more
	15%	3% or more
	19%	1% or more

Other Prima Facie Evidence of Violation

Under the act, an acquisition involving two or more involved insurers competing in the same market is prima facie evidence of a violation of the competitive standards if (1) there is a significant trend toward increased concentration in the market, (2) one of the involved insurers is in a group of large insurance companies that shows this increase, and (3) another involved insurer's market share is 2% or more.

Under the act, there is a significant trend toward increased concentration when the aggregate market share for any grouping of the largest insurance companies in the market, from the two largest to the eight largest, has increased by 7% or more of the market over a period extending from any base year between five and 10 years before the proposed acquisition.

The act defines “market” as the relevant product and geographical markets. In determining these markets, the commissioner must consider any (1) NAIC definitions or guidelines, (2) information submitted by an acquiring or acquired party, and (3) other information he considers relevant. In the absence of sufficient information to the contrary (1) the relevant product market is the direct written insurance premium for a line of business, i.e., a line being used in the annual statement insurance companies doing business in this state must file with the commissioner, and (2) the relevant geographical market is Connecticut.

Rebuttal of Presumption

An acquiring or acquired party may rebut the presumption of a prima facie violation based on substantial evidence of the absence of the requisite anticompetitive effect. The rebuttal may include factors such as the involved insurers' market shares, the volatility of market leader rankings, the number of competitors in the market, the concentration and the trend in concentration in the insurance industry, and ease of entry to and exit from the market.

Other Violations

The act allows the commissioner to find, based on substantial evidence, a violation of the competitive standards that he did not designate as a prima facie violation.

Orders

If the commissioner finds that a proposed acquisition violates the act's competitive standards or an acquiring party either fails to file or fails to provide adequate information in the required notification, the commissioner may issue an order (1) directing an involved insurer to cease and desist from doing business in Connecticut with respect to any line of insurance involved in the violation or (2) denying an involved insurer's application for a license to do business in Connecticut. The order does not apply if the proposed acquisition is not consummated.

The commissioner may not issue this order unless (1) there is a hearing, notice of which is provided to the involved insurers before the end of the waiting period (described above) and at least 15 days before the hearing and (2) the hearing is concluded and the order issued within 60 days after the date the acquiring party filed the notification. The order must be accompanied by the commissioner's written decision setting forth findings of fact and conclusions of law.

The commissioner may not issue an order if the proposed acquisition will (1) yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved any other way or (2) substantially increase the availability of insurance in this state, and either of these benefits exceed those that would arise from not reducing competition in this state.

Penalties

The act subjects any person who violates the commissioner's cease and desist order, after notice and hearing, to a fine of up to \$10,000 for each day of the violation, suspension or revocation of his or her license, or both.

Any person who fails to make a required filing and fails to demonstrate a good faith effort to comply with the filing requirement must be fined up to \$50,000.

REVIEW OF APPLICATION FOR CHANGE OF CONTROL (Sections 2 and 4)

By law, when a domestic insurer is the subject of a proposed merger or change of control, it must submit an application to the Insurance Department containing specified information. The act expands the information that must be included on the application to include acknowledgments by the person filing the statement that:

1. he or she will make a good faith effort to ensure that the annual enterprise risk report required by the act is filed in a timely manner for as long as he or she has control and
2. he or she and all subsidiaries in the insurance holding company system within his or her control will provide information the commissioner requests to evaluate enterprise risk to the insurance company.

Under the act, "enterprise risk" is any activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, will likely have a material adverse effect on the financial condition or liquidity of the insurer or its holding company system as a whole. Among other things, this includes any activity, circumstance, event, or series of events that would cause (1) an insurer's or health care center's (HMO) risk-based capital to fall below the minimum level required by law or (2) an insurer to be in a hazardous financial condition.

Hearing and Review of Application

The act eliminates a requirement that the commissioner hold a hearing on whether to approve a proposed change of control. Under prior law, the person filing the application had to provide notice of the hearing to the insurance company and to anyone else the commissioner designates. Under the act, if a hearing is held, the filer must provide its notice at least seven, rather than at least 15 days, before the hearing. The act also requires the filer to (1) publish notice of the hearing in newspapers in Hartford and other municipalities as the commissioner directs and (2) provide notice in other ways the commissioner deems appropriate.

Under the act, if a proposed merger or other acquisition of control requires the approval of another state's insurance regulatory official, the public hearing may be held on a consolidated basis at the commissioner's discretion. The hearing must be held in the United States before the officials of the states where the insurance companies are domiciled, who must hear and receive evidence. An insurance regulatory official may attend the hearing in person or through telecommunication.

Decision Criteria

By law, the commissioner must make his determination whether to approve the merger or other change in control within 30 days after the hearing. Under the act, if there will be a change of control of a domestic insurance company, the commissioner must, by the same deadline, also

determine whether the acquiring party must maintain or restore the insurance company's capital to the level required under Connecticut law.

The act requires the commissioner to consider (1) the information submitted in the pre-acquisition notification and (2) whether the proposed acquisition will substantially reduce competition in any line of insurance business in the state or tend to create a monopoly here when evaluating the effect of the merger or other acquisition of control on competition in this state.

Under prior law, the commissioner had to approve a merger or other acquisition of control unless he found that:

1. after the change of control, the domestic insurance company would not be able to satisfy the requirements for the issuance of a license to write the line or lines of business for which it was licensed;
2. the transaction would substantially lessen insurance competition in this state or tend to create a monopoly here;
3. the financial condition of any acquiring party might jeopardize the insurance company's financial stability or prejudice the interests of its policyholders;
4. the acquiring party's plans or proposals to liquidate the insurance company, sell its assets, consolidate or merge it with any person, or make any other material change in its business or corporate structure or management were unfair and unreasonable to the insurance company's policyholders and not in the public interest;
5. the competence, experience, and integrity of the persons who would control the insurance company's operations were such that it would not be in the interest of company's policyholders and the public to permit the transaction; or
6. the acquisition was likely to be hazardous or prejudicial to those buying insurance.

The act allows the commissioner to approve a merger or other acquisition of control on the condition of the correction or removal, within a specified period of time, of grounds listed above that would otherwise lead him to disapprove the application.

The act bars the commissioner from disapproving a merger or other acquisition of control based on the above criteria if he finds that the proposed transaction will (1) yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved any other way or (2) substantially increase the availability of insurance in this state, and either of these benefits exceeds those achieved by maintaining the level of competition in the state.

DIVESTITURE OF CONTROL (Sections 2 and 3)

The act requires any person who controls a domestic insurance company and who seeks to divest the controlling interest to file with the commissioner and send to the company a confidential notice of the proposed divestiture at least 30 days before the divestiture. The notice must remain confidential until the conclusion of the divestiture unless the commissioner determines that this will interfere with the enforcement of the insurance law regarding mergers and acquisition of control. The filing requirement does not apply where the divestiture is occurring in conjunction with a merger or acquisition where the application required by law with respect to the transaction has been filed with the commissioner. The commissioner must adopt implementing regulations to govern when a controlling person must obtain his prior approval of a divestiture.

The act subjects a divestiture without the commissioner's approval to the same civil and criminal penalties that apply under the law to gaining control of an insurance company without his approval.

CONFIDENTIALITY OF INFORMATION (Section 8)

Restrictions on Access to Information

By law, all (1) information, documents, and copies obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made under law and (2) information reported, furnished, or filed under the laws requiring companies to be registered and governing transactions between holding companies and insurance companies, is confidential and not subject to subpoena. The act extends this protection to materials submitted in these reviews. It specifies that all of the information and related data is (1) privileged, (2) not subject to disclosure under the Freedom of Information Act, and (3) not subject to discovery or admissible in evidence in any civil action.

Under prior law, the commissioner, NAIC, and any other person could not make this information and data available to the public except to insurance departments of other states. The act instead prohibits the commissioner from making the information, documents, materials, or copies public without the affected insurance company's prior written consent. The company's consent is not needed if the commissioner (1) gives the insurance company and its affiliates who would be affected notice and opportunity to be heard and (2) determines that the interests of policyholders, security-holders, or the public will be served by the publication of the information; in that case, he may publish all or any part of the information as he considers appropriate.

The act prohibits the commissioner and anyone who receives the information, documents, materials, or copies or with whom they are shared, while acting under the commissioner's authority, from testifying or being required to testify in any civil action concerning them.

Permitted Disclosures

The act allows the commissioner to use the information, documents, materials, or copies in the furtherance of any regulatory or legal action brought as part of his official duties.

The act requires the commissioner to enter into written agreements with NAIC governing the sharing and use of information, documents, materials, or copies shared or received under Connecticut law.

It allows the commissioner, for assistance in the performance of his duties, to:

1. share confidential and privileged information, documents, materials, or copies with (a) other state, federal, and international regulatory officials; (b) NAIC or its affiliate or subsidiaries; (c) the International Association of Insurance Supervisors; (d) the Bank for International Settlements; (e) the Federal Insurance Office; (f) state, federal, and international law enforcement authorities; and (g) members or participants of a supervisory college when the commissioner is a member or a participant, provided the recipient agrees, in writing, to maintain their confidentiality and privileged status and has verified, in writing, his or her legal authority to maintain confidentiality;

2. receive information, documents, materials, or copies, including those that are confidential and privileged, from NAIC or its affiliates or subsidiaries, the Federal Insurance Office, International Association of Insurance Supervisors, the Bank for International Settlements, or state, federal, and international law enforcement authorities, provided the commissioner maintains them as confidential and privileged when notified that they are so under the laws of the jurisdiction that is their source; and
3. enter into written agreements with the International Association of Insurance Supervisors and the Bank for International Settlements that govern the sharing and use of information, documents, materials, or copies shared or received under Connecticut law.

The agreements must:

1. specify the procedures and protocols regarding the confidentiality and security of the shared information;
2. specify that the commissioner must retain ownership of the information and that the use of this information by the other entities is subject to his discretion;
3. require prompt notice to be given to an insurance company whose confidential information is in the other entity's possession if it is subject to a request or subpoena for disclosure or production of this information; and
4. require, if the other entity is subject to disclosure of an insurance company's shared confidential information, it must allow the company to intervene in any judicial or administrative action regarding the disclosure or information.

Under the act, no waiver of any applicable privilege or claim of confidentiality in any information, documents, materials, or copies occurs as a result of disclosure to the commissioner or of sharing in accordance with the act. The act cannot be construed to delegate any of the commissioner's regulatory authority to any person or entity with which any information, documents, materials, or copies have been shared. Any information, documents, materials, or copies in the possession of NAIC or its affiliates or subsidiaries, the International Association of Insurance Supervisors, and the Bank for International Settlements must be confidential by law, privileged, and not be subject to discovery or admissible in evidence in any civil action in this state.

EXAMINATION OF ENTERPRISE RISK (Sections 10 and 11)

The act allows the commissioner to examine a registered insurance company or its affiliates to determine the company's financial condition, including its enterprise risk from (1) the company's ultimate controlling person, (2) members within its insurance holding company system, or (3) its insurance holding company system on a consolidated basis.

The act allows the commissioner to order an insurance company to produce records, books, or other information it does not have in its possession if it can obtain access to them under a contractual agreement, statutory obligation, or other method. If the company cannot obtain access to the information, it must give the commissioner a detailed explanation of why it cannot and identify who holds the information. If the commissioner finds the explanation to be without merit, the delay in producing the information is grounds for suspending, revoking, or refusing to renew the insurer's license as provided by law.

Sanctions for Violation

The act allows the insurance commissioner to (1) disapprove dividends and other distributions and (2) place an insurer under administrative supervision as authorized by law, when it appears to the commissioner that any person has violated the laws governing changes in the control of an insurance company in a way that prevents the full understanding of the enterprise risk posed to the insurer by its insurance holding company system or affiliates.

REGISTRATION REQUIREMENTS FOR COMPANIES THAT ARE PART OF HOLDING COMPANY SYSTEMS (Sections 6 and 8)

By law, each insurance company that is authorized to do business in Connecticut and is a member of an insurance holding company system must register with the commissioner and file a registration statement containing specified information. The act requires that the statement also include:

1. statements that the company's board of directors oversees its corporate governance and internal controls, and that its officers or senior management have approved, implemented, and continue to maintain the governance and controls;
2. if requested by the commissioner, financial statements of or within an insurance holding company system, including all affiliates, that may include annual audited financial statements filed with the Securities and Exchange Commission under federal law, and can be those of the insurance company or its parent corporation; and
3. any other information required by department regulations.

The act requires that the controlling person of each insurance company required to register under these provisions file an enterprise risk report in a form and manner prescribed by the commissioner. The initial report cannot be filed before June 1, 2013; the act does not specify a deadline for filing the initial report. PA 12-2, June 12 Special Session instead requires the first report to be filed by June 1, 2013.

The report must identify, to the best of the person's knowledge and belief, the material risks within the insurance holding company system that could pose enterprise risk to the insurance company.

The report must be filed with the lead state commissioner as determined by the procedures in NAIC's applicable financial analysis handbook. It must (1) be confidential by law and privileged, (2) be exempt from the Freedom of Information Act, (3) not be subject to subpoena, and (4) not be subject to discovery or admissible in any civil action.

The commissioner may not make the report public without the filer's prior written consent. But the commissioner can disclose the information, after giving the filer and the insurance company to which the report pertains and its affiliates in the insurance holding company system who would be affected notice and opportunity to be heard, if he determines that the interests of policyholders, security holders, or the public will be served by the disclosure. In this case, the commissioner may publish all or part of the information in a way he considers appropriate.

The commissioner may also use the report in the furtherance of any regulatory or legal action brought as part of his official duties. He may share the enterprise risk report only with the

insurance regulatory official of another state with laws or regulations substantially similar to Connecticut's who has agreed, in writing, to maintain the report's confidentiality and privileged status.

By law, the failure to file a registration statement or any amendment or addition is subject to a variety of criminal and civil sanctions. The act extends these sanctions to apply to the failure to file a summary or an enterprise risk report.

SUPERVISORY COLLEGES (Section 6)

In order to assess the business strategy, financial, legal, or regulatory position risk exposure; risk management; or governance processes of a domestic insurance company that must register and that is part of an insurance holding company system with international operations, the act allows the commissioner to initiate, be a member of, or participate in a supervisory college. This is a temporary or permanent forum for communication between and cooperation among state, federal, and international regulatory officials. The commissioner must take this action in the context of an examination of a company as permitted by law.

If the commissioner initiates a supervisory college, he must:

1. establish its membership and participation in it by state, federal, or international regulatory officials;
2. establish its functions and the role of members and participants;
3. select a chairperson for it;
4. coordinate its activities, including meeting planning and processes for information sharing that comply with the law's applicable confidentiality provisions; and
5. establish a crisis management plan for the supervisory college.

The act allows the commissioner to enter into written agreements with state, federal, or international regulatory officials governing the activities of a supervisory college. The agreements must maintain the confidentiality requirements of Connecticut law.

Under the act, each insurance company subject to registration must be assessed for and pay to the commissioner its share of the reasonable costs, including reasonable travel expenses, of the commissioner's participation in a supervisory college. The payment is in addition to any other taxes, fees, and money otherwise payable to the state. The commissioner must establish the assessment method for these costs and provide reasonable notice to each insurance company subject to an assessment.

These provisions do not affect the commissioner's authority to regulate an insurance company or its affiliate under the commissioner's jurisdiction or to delegate his regulatory authority to a supervisory college.

TRANSACTIONS BETWEEN INSURANCE AND HOLDING COMPANIES (Section 7)

By law, certain transactions involving a domestic insurance company and any person in its holding company system may not be entered into unless (1) the insurance company has notified the commissioner in writing of its intent to enter into them at least 30 days in advance, or any

shorter period the commissioner may specify, and (2) the commissioner has approved or not disapproved the transaction within this period.

The act specifies that these provisions apply to amendments to or modifications of affiliate agreements previously filed under the law that meet any of its materiality standards. The act also requires that the written notice for these amendments or modifications specify the reasons for the change and the financial impact on the domestic insurance company. Within 30 days after the termination of a previously filed agreement, the insurance company must notify the commissioner of the termination in order for him to determine what written notice or filing is required, if any.

The act subjects all, rather than just material, management agreements, service contracts, and cost-sharing arrangements to the notice and approval requirements. It also expands the types of transactions subject to these requirements to include:

1. guarantees by a domestic insurance company, although those that are (a) quantifiable as to amount and (b) do not exceed the lesser of 0.5% of the company's admitted assets or 10% of surplus with regard to policyholders as of the last December 31st, are not subject to the notice requirement, and
2. direct or indirect acquisitions or investments in a person that controls the insurance company or in an affiliate of the company in an amount that, together with the insurance company's present holdings, exceeds 2.5% of the insurance company's surplus with regard to policyholders. The latter provision does not apply to direct or indirect acquisitions of or investments in (1) subsidiaries acquired as allowed by law or (2) non-subsidiary affiliates that are subject to the law.

Public Act 12-2, June 12, 2012 Special Session (Senate Bill 501)
An Act Implementing Certain Provisions Concerning Government Administration
(Signed by the Governor 6/15/2012)

Sections 126 and 173 — Regulation of Insurance Companies

The act advances, from October 1, 2012 to July 1, 2012, the effective date of provisions of PA 12-103 (§ 6) that allow the insurance commissioner to initiate, be a member of, or participate in a supervisory college. A supervisory college is a temporary or permanent forum for communication between and cooperation among state, federal, and international regulatory officials.

EFFECTIVE DATE: July 1, 2012

Section 127 & 173 – INSURANCE HOLDING COMPANIES

The act makes a minor change in PA 12-103's provisions regarding insurance holding companies. By law, each insurance company authorized to do business in Connecticut and a member of a holding company system must register with the insurance commissioner and file a registration statement containing specified information. PA 12-103 additionally requires the person controlling an insurance company subject to the registration requirement to file an annual

statement regarding the risks within the holding company system that pose a risk to the company. The act requires that the first statement be filed by, rather than not before, June 1, 2013.

EFFECTIVE DATE: October 1, 2012

Public Act 12-139 (House Bill 5484)

An Act Concerning Credit Allowed a Domestic Ceding Insurer for Reinsurance

(Signed by the Governor 6/4/2012)

The law specifies an accounting procedure for insurers transferring all or part of their insurance or reinsurance risk written to another insurer or reinsurer. Under this statutory procedure, the ceding insurer may treat amounts due from reinsurers as assets or reductions from liability based on the reinsurer's status.

Reinsurance is a transaction between two or more insurance companies to apportion risk so that a large loss does not fall on any one company. The insurer transferring part of the risk to another insurer is called the ceding or domestic insurer. The insurer accepting the risk is called the assuming insurer or reinsurer.

This act modifies and expands the options under which a U. S. ceding insurer may take credit for reinsurance on its financial statements. For example, it allows credit to be taken when the reinsurance is ceded to a reinsurer that (1) is certified or accredited by the insurance commissioner and (2) secures its reinsurance obligations in accordance with the bill and regulations to be adopted by the commissioner. The act allows the commissioner to suspend or revoke a reinsurer's certification or accreditation if he determines the reinsurer no longer meets the applicable requirements.

Under the act, the commissioner evaluates a reinsurer that applies for certification and assigns a rating based on the evaluation. The commissioner's rating determines the amount of collateral the certified reinsurer must maintain to secure obligations it assumes from U. S. ceding insurers. If a certified reinsurer secures its obligations at a level consistent with its rating, the ceding insurer will qualify for full financial credit for the reinsurance.

EFFECTIVE DATE: October 1, 2012

CREDIT FOR REINSURANCE (Section 1)

The act expands the scenarios under which credit for reinsurance is allowed a ceding insurer as either an asset or a deduction from liability. By law, credit is allowed when the reinsurer meets one of the following requirements:

1. it is licensed as an insurer or reinsurer or accredited in Connecticut;
2. it is domiciled and licensed in a state with reinsurance standards similar to Connecticut's or, if a U. S. branch of a reinsurer chartered outside the United States (i.e., an "alien" reinsurer), conducts business through a state with reinsurance standards similar to Connecticut's, and meets certain capital surplus and other requirements;
3. it maintains a trust in a qualified U. S. financial institution for the payment of claims of U. S. policyholders and ceding insurers; or

4. the insurance is on a risk located in a jurisdiction where reinsurance is required by law or regulation.

The act also allows credit for reinsurance when the reinsurer is certified by the commissioner under § 2 of the act and maintains specified security.

By law, if the reinsurer does not meet any of these criteria, the ceding insurer can still reduce its liability if the reinsurer holds security in an amount adequate to cover claims that could arise pursuant to the reinsurance contract. The act provides that the ceding insurer can also claim a credit if it agrees to specified conditions in the trust instrument.

Accredited Reinsurers

By law, a credit for reinsurance is allowed when the reinsurer is accredited in Connecticut. Under prior law, an accredited reinsurer is one that:

1. files evidence of its submission to this state's jurisdiction;
2. allows the state to examine its books and records;
3. is licensed to transact insurance or reinsurance business in at least one state, or if a U. S. branch of an alien reinsurer, conducts business and is licensed in at least one state;
4. files a copy of its annual statement and most recent audited financial statement with the Insurance Department; and
5. maintains a surplus of (a) at least \$20 million if the commissioner has not denied its accreditation application within 90 days of receipt or (b) less than \$20 million if the commissioner has approved its accreditation application.

The act retains the first four criteria. In place of the fifth criterion, it adds a requirement that the insurer demonstrate to the commissioner's satisfaction that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from a domestic insurer.

The act specifies that a reinsurer is deemed to meet the accreditation requirements if it maintains a surplus of at least \$20 million and the commissioner has not denied its accreditation within 90 days of receipt of the application.

Trust Requirements

By law, a credit for reinsurance is allowed when the reinsurer maintains a trust in a qualified U. S. financial institution. The reinsurer must annually report to the commissioner information to enable him to determine the sufficiency of the trust.

The act requires the reinsurer also to allow the commissioner to examine, at the reinsurer's expense, its books and records.

The act requires the trust to be approved by the insurance regulatory official of (1) the trust's home state or (2) another state that has accepted principal regulatory oversight of the trust. It also requires the trust's forms and amendments to be filed with the insurance regulatory officials of each state in which ceding insurer trust beneficiaries are domiciled.

Single Reinsurer. Under prior law, in the case of a single reinsurer, the trust had to consist of an account covering its U. S. liabilities and a surplus of at least \$20 million. The act instead requires the trust to cover at least the reinsurer's U. S. reinsurance liabilities and a surplus of at least \$20 million; but the commissioner may, in certain circumstances, reduce the surplus amount for a trust over which he has principal regulatory oversight.

The commissioner may authorize a reduction in the surplus if the reinsurer, for at least three years, has permanently discontinued underwriting new business secured by the trust. The commissioner must conduct a risk assessment to determine that the reduced surplus level is adequate. The assessment (1) may involve an actuarial review and (2) must consider all material risk factors. The minimum required surplus cannot be less than 30% of the reinsurer's U. S. reinsurance liabilities.

Group of Reinsurers. Under prior law, in the case of a group of reinsurers, including incorporated and individual unincorporated underwriters, the trust had to consist of an account covering its U. S. liabilities and a surplus of at least \$100 million. The act retains this requirement for reinsurance ceded before January 1, 1993. For reinsurance ceded on or after January 1, 1993, the act instead requires the trust to cover at least the reinsurer's U. S. reinsurance liabilities and a surplus of at least \$100 million.

Under prior law, the group had to annually certify each member's solvency to the commissioner through the regulator of their place of domicile and their independent public accountants. The act requires the group to provide the commissioner information within 90 days after the group's financial statements are due to its domiciliary regulator. The information must be (1) a solvency certification from the group's domiciliary regulator or (2) financial statements prepared by each member's independent public accountants.

Group of Incorporated Underwriters. The act establishes specific requirements regarding trusts when the assuming insurer is a group of incorporated underwriters under common administration. In such cases, the trust must consist of an account covering its U. S. reinsurance liabilities and a (1) policyholders' surplus of at least \$10 billion and (2) joint trusteed surplus, of which \$100 million must be held jointly for the benefit of U. S. ceding insurers of any member of the group as additional security for these liabilities. The group must be accredited and have continuously conducted insurance business outside the United States for at least the three years before applying for accreditation.

The act requires the group to give the commissioner information within 90 days after the group's financial statements are due to its domiciliary regulator. The information must be (1) a solvency certification from the group's domiciliary regulator or (2) financial statements prepared by each member's independent public accountants.

Certified Reinsurers

The act allows a ceding insurer to take credit for reinsurance when the reinsurer is certified by the commissioner (see § 2) and maintains security in the form and amounts specified for trusts.

Under the act, if the security is not sufficient to cover the certified reinsurer's obligations, the commissioner (1) must reduce the credit allowed proportionately to the deficiency and (2) may further reduce the credit allowed if he finds there is a material risk that obligations will not be paid in full when due.

Additional Trust Requirements for Certain Reinsurers

The act allows credit for reinsurers who are not licensed or accredited in Connecticut or conducting business through a state with reinsurance standards similar to Connecticut's if they satisfy additional trust requirements.

If the trust contains less than the amount required or if the trust grantor is insolvent or in receivership or a similar proceeding in its domiciliary jurisdiction, the trustee must comply with the principal regulator's or court's order requiring the trustee to transfer the trust assets to the regulator. The regulator must distribute the assets in accordance with the domicile's liquidation laws. If the regulator returns any assets to the trustee after liquidation, the trustee must distribute them in accordance with the trust instrument.

The act requires the trust grantor to waive any right under law that is inconsistent with these provisions.

Accreditation or Certification Suspension or Revocation

Prior law allowed the commissioner to revoke a reinsurer's accreditation after notice and a hearing. The act instead authorizes the commissioner to suspend or revoke a reinsurer's accreditation or certification, after notice and hearing, if he determines the reinsurer no longer meets the applicable requirements.

If a certified reinsurer's domiciliary jurisdiction stops being a qualified jurisdiction (see § 2), the commissioner may suspend the reinsurer's certification indefinitely, instead of revoking it.

The act authorizes the commissioner to suspend or revoke a reinsurer's accreditation or certification without notice and a hearing if the:

1. reinsurer waives its right to a hearing;
2. reinsurer's home state took regulatory action against the reinsurer;
3. reinsurer voluntarily surrenders or terminates its eligibility to transact business in its home state or primary certifying jurisdiction; or
4. commissioner determines that immediate action is needed to protect the public and a court has not blocked the action.

No credit for reinsurance is allowed if the reinsurer's accreditation or certification is suspended or revoked, except to the extent that the reinsurer's obligations are secured in accordance with the bill.

A reinsurer whose certification has been suspended, revoked, voluntarily surrendered or is inactive must be treated as a certified reinsurer required to secure 100% of its obligations. But this does not apply to a reinsurer whose certification has been suspended or is inactive if the commissioner continues to assign a high rating to the reinsurer under § 2 of the act.

Anyone aggrieved by the commissioner's action to suspend or revoke an accreditation or certification may appeal the order to the commissioner within 30 days after receiving it. By law, the commissioner must hold a hearing on an appeal within 30 days after receiving the request and make a decision within 45 days after the hearing.

Ceding Insurer Must Manage Reinsurance Program

The act requires a ceding insurer to safely manage its reinsurance program.

Specifically, the ceding insurer must manage its reinsurance recoverables in proportion to its own book of business. It must notify the commissioner within 30 days after (1) reinsurance recoverables from any one reinsurer or group of reinsurers exceeds 50% of the ceding insurer's last reported surplus to policyholders or (2) it determines the recoverables are likely to exceed that limit.

The ceding insurer also must manage its reinsurance program to ensure diversification. It must notify the commissioner within 30 days after it (1) has ceded to any one reinsurer or group of reinsurers more than 20% of its gross written premiums in the prior calendar year or (2) determines that the reinsurance ceded is likely to exceed that limit.

A notification to the commissioner must demonstrate that the ceding insurer is safely managing its exposure.

CERTIFICATION (Section 2)

The act allows a reinsurer to get credit for reinsurance if it is certified by the Insurance Department.

Certification Eligibility

Under the act, to be eligible for certification, a reinsurer must:

1. be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction (see below);
2. maintain minimum capital and surplus in amounts the commissioner prescribes in regulations;
3. maintain financial strength ratings from at least two rating agencies the commissioner deems acceptable in regulations; and
4. comply with any other requirements the commissioner determines necessary for certification.

To be eligible for certification, a reinsurer must also agree to:

1. submit to Connecticut's jurisdiction and appoint the commissioner as its agent for service of process;
2. provide security for 100% of its U. S. reinsurance liabilities if it resists enforcement of a final court judgment;
3. if it secures its obligations in a multibeneficiary trust, upon the termination of any trust account within the trust, fund any deficiency out of the remaining trust surplus; and
4. meet applicable filing requirements the commissioner prescribes.

If an applicant has been certified as a reinsurer in a jurisdiction accredited by the National Association of Insurance Commissioners (NAIC), the commissioner may (1) certify the applicant

as a certified reinsurer in Connecticut and (2) accept the rating assigned to the reinsurer by that jurisdiction.

If the applicant is a group of reinsurers, including incorporated and individual unincorporated underwriters, it must also comply with the following requirements:

1. The group must comply with the minimum capital and surplus requirements through the capital and surplus equivalents, less current liabilities, of the group and its members. The equivalents must include a joint central fund in an amount the commissioner determines to provide adequate financial protection for any unsatisfied obligations.
2. The incorporated members of the group (a) cannot be engaged in any business other than underwriting as a group member and (b) must be subject to the same level of regulatory and solvency control as the unincorporated members.
3. The group must provide the commissioner information within 90 days after the group's financial statements are due to its domiciliary regulator. The information must be (a) a solvency certification from the group's domiciliary regulator or (b) financial statements prepared by each member's independent public accountants.

Qualified Jurisdictions

The act requires the commissioner to publish a list of qualified jurisdictions from which a reinsurer is eligible for certification in Connecticut. In developing the list, the commissioner must consider the NAIC's list of qualified jurisdictions. Any state that is NAIC-accredited must be a qualified jurisdiction.

If the commissioner qualifies a jurisdiction that is not on the NAIC list, he must publish a justification. The act requires the commissioner to adopt regulations to establish criteria for justifying a qualification.

The act requires the commissioner, when deciding if the home country of an alien reinsurer is a qualified jurisdiction, to (1) evaluate the appropriateness and effectiveness of that country's reinsurance regulatory system; (2) consider the rights, benefits, and extent of reciprocity that country provides to U. S. reinsurers, including whether the country shares information and cooperates with the commissioner regarding certified reinsurers; and (3) consider any other factors he deems relevant.

The act prohibits the commissioner from qualifying a country that does not adequately and promptly enforce final U. S. judgments of arbitration awards.

Rating System

The act requires the commissioner, after considering the financial strength ratings assigned by acceptable rating agencies, to assign a rating to each certified reinsurer. He must publish a list of certified reinsurers and their assigned ratings.

It requires the commissioner to adopt regulations to identify the acceptable rating agencies, establish the rating system methodology, and set the level of security required for each rating.

Under the act, a certified reinsurer must secure its U. S. reinsurance obligations at a level consistent with its assigned rating.

If the certified reinsurer secures obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer in the form of a multibeneficiary trust, it must maintain separate trust accounts for (1) such obligations incurred and (2) obligations subject to the trust requirements contained in § 1 (see above). The act specifies that the minimum trustee surplus requirements of § 1 do not apply to a multibeneficiary trust. Rather, such a trust must maintain a surplus of at least \$10 million.

If a certified reinsurer stops reinsuring new business in Connecticut, it may ask the commissioner to move its certification to an inactive status, allowing it to still qualify for reduced security for its in-force business. An inactive certified reinsurer must still comply with the act's applicable certification requirements. The commissioner must assign a new rating to the inactive certified reinsurer to account for any relevant reasons why the reinsurer is not reinsuring new business.

CREDIT FOR ASSET OR REDUCTION IN LIABILITY (Section 3)

Existing law permits one final method for a ceding insurer to reduce liability through reinsurance. It allows the ceding insurer to take a reduction up to the amount of the liability carried by the ceding insurer when the reinsurer does not meet any of the other requirements specified in the law but meets certain security requirements. The act expands this to allow the ceding insurer to take either a credit for an asset or a reduction in liability and broadens the eligible securities to include securities listed by the NAIC Securities Valuation Office that are exempt from filing.

Thus, under the act, the credit or reduction must equal the amount of funds held by or on behalf of the ceding insurer as security for the payment of the reinsurance obligations. It must be held (1) in the United States, subject to withdrawal solely by, and under the exclusive control of, the ceding insurer or (2) in trust in a qualified U. S. financial institution. The security may be in:

1. cash;
2. securities listed by the NAIC Securities Valuation Office, including those deemed exempt from filing, and qualifying as admitted assets;
3. a clean, irrevocable, and unconditional letter of credit issued by a qualified institution that is effective by December 31 of the year in which the filing is made and in the ceding insurer's possession before the filing date of its annual statement; or
4. any other form of security acceptable to the commissioner.

Letters of credit meeting standards of acceptability on the date of issuance will continue to be accepted as security until their expiration, extension, renewal, modification, or amendment despite the issuing institution's failure to meet such standards.

TECHNICAL AND CONFORMING CHANGES (Sections 4 and 6)

These sections make technical and conforming changes.

Acts of Direct Interest to the Insurance Department
Life and Health

Public Act 12-44 (Senate Bill 205)

An Act Concerning Insurance Coverage for the Birth-to-Three Program

(Signed by the Governor 5/31/2012)

This act changes requirements for individual and group health insurance policies that provide coverage for medically necessary early intervention (birth-to-three) services as part of an individualized family service plan.

Existing law prohibits payments for birth-to-three services from applying against any maximum lifetime or annual limit in the policy. The act also prohibits payments from causing:

1. a loss of benefits due to a policy limit,
2. an insured child or family member to be denied health insurance coverage, and
3. a policy rescission or cancellation.

The act specifies that payments for birth-to-three services must be treated the same as other claim experience for premium rating purposes.

The act also expands the list of policies that must provide birth-to-three coverage to include certain policies amended or continued in Connecticut, rather than only those delivered, issued, or renewed here.

EFFECTIVE DATE: July 1, 2012

APPLICABILITY

The act applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including coverage under an HMO plan.

Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

BACKGROUND

Birth-to-Three Coverage Requirements

Individual and group health insurance policies must cover at least \$6,400 per child annually for medically necessary birth-to-three services, up to \$19,200 per child over three years. For children with autism receiving birth-to-three services, group health insurance policies must cover at least \$50,000 per child annually, up to \$150,000 per child over three years.

Individual and group policies cannot impose out-of-pocket expenses (e. g., coinsurance, copayments, or deductibles) for birth-to-three services, except for a high-deductible health plan designed to be compatible with federally qualified health savings accounts.

Public Act 12-61 (Senate Bill 12)
An Act Concerning Guidelines for Health Insurance Coverage for Colorectal Cancer Screening
(Signed by the Governor 5/31/2012)

This act changes the entity whose recommendation health insurers must follow in determining the level of coverage to provide for colorectal cancer screening. By law, specified health insurance policies must cover colorectal cancer screening, including colonoscopies, sigmoidoscopies, and radiological imaging. Under prior law, they had to follow recommendations established by the American College of Gastroenterology, after its consultation with the American Cancer Society and the American College of Radiology. The act instead requires them to cover the tests in accordance with the American Cancer Society's recommendations.

The affected policies are 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. Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2013

Public Act 12-145 (House Bill 5011)
An Act Concerning the Legislative Commissioners' Recommendations for Technical and Minor Changes to the Insurance Statutes
(Signed by the Governor 6/15/2012)

This act expands the circumstances under which certain health insurance mandates apply. It also corrects statutory references and makes other minor and technical changes to the insurance laws.

EFFECTIVE DATE: Upon passage, except the mandate changes take effect January 1, 2013.

HEALTH INSURANCE MANDATES

By law, insurance companies, fraternal benefit societies, hospital service corporations, medical service corporations, and Health Care Centers (i.e., HMOs) that issue, renew, or continue a Medicare supplement policy must file a request for approval with the Insurance Department at least 60 days before changing their rates. The act extends this requirement to amended policies. By law, the department must hold a hearing and has 45 days from receiving the request to approve or deny it.

Under existing law, requirements that health insurers offer specified benefits apply to new and renewed policies and, in most cases, to policies amended or continued on or after the mandate's effective date. As described in Table 1, the act requires coverage of amended or continued policies in those cases where this was not previously required. The mandates apply to individual and group policies.

Table 1: Expansion of Applicability of Health Benefit Mandates

<i>Benefit</i>	<i>Expansion</i>
Amino acid modified preparations and low protein modified food products when prescribed for the treatment of inherited metabolic diseases	Amended or continued policies
Medically necessary specialized formula	Amended or continued policies
Medically necessary prescription drugs removed from formulary	Amended policies
Medically necessary ambulance services	Continued policies

The act also specifies that the mandate regarding amino acid modified and low protein modified food products does not apply to accident-only policies.

Public Act 12-150 (Senate Bill 97)
An Act Concerning Guidelines for Health Insurance Coverage for Breast Magnetic Resonance Imaging
(Signed by the Governor 6/15/2012)

This act removes a requirement that specified health insurance policies cover breast magnetic resonance imaging (MRI) under the same circumstances as breast ultrasound screening (i.e., when a woman has dense breast tissue or an increased risk of breast cancer). It also removes a requirement that the policies cover MRIs in all circumstances according to guidelines established by the American College of Radiology. It specifies that the policies must cover breast MRIs in accordance with American Cancer Society guidelines.

EFFECTIVE DATE: Upon passage

APPLICABILITY

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. They also apply to individual policies that cover limited benefit health coverage. (Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.)

Public Act 12-190 (Senate Bill 98)
An Act Concerning Deductibles for Screening Colonoscopies and Screening Sigmoidoscopies
(Signed by the Governor 6/15/2012)

This act bars insurers from charging a deductible for procedures a physician initially undertakes as a colorectal cancer screening colonoscopy or sigmoidoscopy. (A colonoscopy covers the entire lower intestine; a sigmoidoscopy extends only to the lower colon.) Under prior law, some

insurers charged a deductible when these screening procedures discovered a polyp, which was removed during the screening.

The affected individual and group health insurance policies are those delivered, issued, amended, renewed, or continued that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan. Due to the federal Employee Retirement and Income Security Act (ERISA), state health insurance mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2013

Public Act 12-197- Sections 20 and 21 (House Bill 5514)
An Act Concerning Various Revisions to the Public Health Statutes
(Signed by the Governor 6/15/2012)

Sections 20 & 21 – Physiatrists as Pain Management Specialists

By law, certain individual and group health insurance policies that are delivered, issued for delivery, renewed, amended, or continued in Connecticut must provide access to a pain management specialist and coverage for pain management treatment ordered by such specialist.

For this purpose, the law defines a “pain management specialist” as a physician credentialed by the American Academy of Pain Management or a board-certified anesthesiologist, neurologist, oncologist, or radiation oncologist with additional training in pain management. The act adds board-certified physiatrists with such additional training to this list. (Physiatrists are physicians who specialize in physical medicine and rehabilitation.)

EFFECTIVE DATE: Upon passage

Acts of Direct Interest to the Insurance Department
Property and Casualty

Public Act 12-123 (House Bill 5143)

An Act Concerning Insurance Coverage for Perishable Food Donated by Certain Food Establishments

(Signed by the Governor 6/15/2012)

This act requires insurers that sell commercial risk insurance policies or riders that cover food spoilage to cover, to the same extent, donations of perishable food to temporary emergency shelters, under narrow circumstances and subject to several limitations. The requirement applies to a policy or rider delivered, issued for delivery, renewed, amended, or continued in this state for a class III or class IV food establishment under the public health code (e. g. , grocery stores and restaurants).

The act exempts a food establishment that makes a donation under these circumstances from liability for civil damages or criminal penalties resulting from the food's nature, age, condition, or packaging, unless it is established that the donor, when making the donation, knew or had reasonable grounds to believe that the food was (1) embargoed or ordered destroyed by the Department of Public Health (DPH), a local health director, or an authorized agent; (2) adulterated; or (3) not fit for human consumption.

To the extent a tax deduction or tax credit is allowed under state law for such donations, no food establishment that donates perishable food under the act and receives payment from an insurer for the donation may claim the tax deduction or credit for the amount of the payment.

EFFECTIVE DATE: October 1, 2012

INSURANCE COVERAGE OF DONATED FOOD

Under the act, any insurer that delivers, issues for delivery, renews, amends, or continues a commercial risk insurance policy or rider in the state that covers the spoilage of perishable food must provide coverage to the same extent for perishable food donated to a temporary emergency shelter operated or supervised by a municipality or the state during a state of emergency for a limited time, if:

1. the governor proclaims a state of emergency;
2. as a result or as part of the emergency, an electrical outage or interruption of electrical service to the insured has occurred and the insured's electric supplier forecasts that the outage will last longer than the period prescribed by DPH, the local health director, or an authorized agent for the safe handling of perishable food;
3. the food is donated while it is still safe to handle; and
4. the insured gives the insurer written documentation from the shelter indicating the date and time of the donation.

The food establishment may not donate the food if (1) DPH, the local health director, or an authorized agent has embargoed or ordered it destroyed; (2) the Department of Consumer Protection or its authorized agent has deemed the food to be adulterated; or (3) the food is not fit

for human consumption. As a result, there is no immunity from liability if the establishment donates food under these circumstances.

Public Act 12-162 (House Bill 5230)

An Act Concerning Various Changes to Property and Casualty Insurance Statutes
(Signed by the Governor 6/15/2012)

This act broadens the applicability of standard fire insurance policy provisions regarding the (1) period when a loss is payable after proof of loss, (2) period when a suit or action for the recovery of a claim must be commenced, and (3) definitions of actual cash value and depreciation.

The act specifies when insurers may impose a hurricane deductible, instead of an overall policy deductible, under homeowners and certain other policies issued or renewed on or after July 1, 2012. (PA 12-2, June 12 Special Session, amends this provision to apply to policies issued or renewed on or after October 1, 2012.)

The act requires people who mitigate losses incurred on or after July 1, 2012 that are covered by a personal risk insurance or commercial risk policy to give the insured, before any work begins, written notice of the work to be completed and the estimated total price. If the person performing the mitigation does not do so, any contract for the mitigation between that person and the insured is void. The requirement does not apply to repairs to an automobile covered by insurance or repairs that are covered by the laws governing home improvement contractors. The act does not define "mitigation." These provisions already apply to repairs and remediation.

By law, insurance adjusters may not charge or collect a fee if, within 30 days of a loss to a structure covered by a fire insurance policy, the insurer offers in writing to pay the full policy limits. The act requires that any fee the adjuster charges the insured be (1) based only on the amount of the insurance settlement proceeds the insured actually receives and (2) collected by the adjuster after the insured has received the proceeds from the insurer.

EFFECTIVE DATE: July 1, 2012, except that the hurricane deductibles provisions are effective October 1, 2012.

EXTENSION OF STANDARD FIRE INSURANCE POLICY REQUIREMENTS

By law, a fire insurance policy must meet various requirements. A policy that covers against fire and other perils generally does not need to meet these requirements with regard to coverage of perils other than fire.

The act extends to the coverage against these other perils the provisions of standard fire policies that specify the following:

1. The amount of loss for which the company is liable is payable 30 days after it receives proof of loss and the loss is ascertained. The company and the insured may agree in writing to a partial payment as an advance payment, but this does not affect the requirement for the company to pay the total amount of loss within 30 days after proof of loss.

2. No suit or action on the policy for the recovery of any claim may be sustained in any court unless all the requirements of the policy have been complied with and the suit or action is commenced within 18 months after the loss.
3. The actual cash value at the time of loss for a building is the amount it would cost to repair or replace the building with material of like kind and quality, minus reasonable depreciation. Depreciation means a decrease in the value of real property over a period of time due to wear and tear.

These provisions apply to policies or contracts issued or renewed on or after July 1, 2012.

HURRICANE DEDUCTIBLES

The act allows insurers to impose a hurricane deductible for losses claimed in the policy, in lieu of an overall policy deductible, for homeowners and certain other policies issued or renewed on or after July 1, 2012, which would be invoked if a hurricane results in a maximum sustained surface wind of 74 miles per hour or more for any part of the state. This provision applies to a (1) homeowners', tenants', mobile manufactured home, and other property and casualty insurance policy for personal, family, or household needs other than workers' compensation insurance; (2) condominium association master policy; and (3) unit owners' association property insurance policy.

The deductible applies to any losses occurring from the time the National Hurricane Center issues a hurricane warning for any part of this state and ends 24 hours after the center (1) terminates the last hurricane warning for any part of this state or (2) issues its last downgrade of the hurricane from hurricane status for any part of this state, whichever is earlier.

The act allows the insurance commissioner to adopt regulations to implement this provision and the department's most current guidelines and bulletins dealing with hurricane deductibles.

Public Act 12-2, June 12, 2012 Special Session - Section 95 (Senate Bill 501)
An Act Implementing Certain Provisions Concerning Government Administration
(Signed by the Governor 6/15/2012)

Hurricane Deductible (Section 95)

The act amends PA 12-162, which, beginning October 1, 2012, specifies when insurers may impose a hurricane deductible under homeowners and certain other policies issued or renewed on or after July 1, 2012. The act allows insurers to apply this deductible to policies issued or renewed on or after October 1, 2012, thus preventing the provision's retroactive application.

Acts of Direct Interest to the Insurance Department
Consumer Affairs

Public Act 12-36 (House Bill 5498)

An Act Concerning Changes to the Funeral Services Statutes

(Signed by the Governor 5/14/2012)

This act allows people to pay for funeral service contracts by assigning the death benefit under a life insurance policy. It exempts contracts that are funded in this way from the general requirement that funeral service establishments (“funeral homes”) deposit into escrow the money or securities they receive under funeral service contracts.

The act allows a legal representative of a funeral service contract beneficiary to authorize the transfer of an irrevocable contract from one funeral home to another. Prior law allowed only the beneficiary to authorize a transfer. The act also makes a technical change specifying that the law's definition of funeral service contract applies to irrevocable funeral service contracts.

The act requires death certificates filed in paper form to be filed with the registrar of vital statistics in the town where the death occurred within five business days, rather than five calendar days, after death, to obtain a burial permit.

It requires funeral homes to maintain the original, signed cremation authorization form for at least six years, rather than at least 20 years, after it was signed by the person with custody and control of the deceased person's remains. This change conforms to another provision in existing law requiring funeral homes to keep cremation authorizations and several other documents for at least six years.

Under existing law, the Department of Social Services must exclude up to \$1,800 in burial funds when determining eligibility for the State Supplement and Temporary Family Assistance programs. Burial funds may be in the form of, among other things, the face value of a life insurance policy if the cash surrender value is excluded. The act specifies that the value must be excluded through the irrevocable transfer of the policy's ownership to a trust.

The act also makes minor, technical, and conforming changes.

EFFECTIVE DATE: Upon passage, except for the provisions on death certificates and cremation authorizations, which are effective October 1, 2012.

LIFE INSURANCE BENEFIT AS PAYMENT FOR FUNERAL SERVICE CONTRACT

The act allows people to pay for funeral service contracts by assigning the death benefit payable under a life insurance policy. Previously, these types of payment arrangements did not fall within the law's definition of a funeral service contract.

Prior law defined a funeral service contract as a contract that requires the payment of money or the delivery of securities in exchange for the final disposition of a dead human body, including funeral, burial, or other services, or the furnishing of personal property or funeral merchandise in

connection with the disposition, where the use or delivery of the services, property, or merchandise is not required immediately. Such contracts are sometimes referred to as “prepaid” or “preneed” funeral service contracts because the person is paying for services to be provided in the future.

The act expands this definition to include contracts that require the assignment of a death benefit payable under an individual or group life insurance policy in exchange for such a final disposition.

Exemption from Escrow Requirements

The law requires funeral homes to deposit any money or securities they receive under a funeral service contract in an escrow account, and sets various related requirements. These requirements include, among other things, that (1) the funeral home appoint an escrow agent to administer the account, (2) account assets be invested only in specified ways, (3) money in the account be removed only as specified by law, and (4) parties to the contract receive annual statements.

Under the act, funeral service contracts funded through an assignment of a death benefit payable under a life insurance policy are exempt from these escrow-related requirements. As a corollary, the act also exempts such contracts from the law's requirement that funeral service contracts contain various provisions related to the escrow requirement.

The act makes related conforming changes. For example, the law requires funeral homes to keep a list of the names and addresses of the escrow agents for their contracts; the act requires them to also keep a list of the names and addresses of insurance companies issuing life insurance policies related to their contracts.

Public Act 12-102 (Senate Bill 410)

An Act Concerning Adverse Determination Reviews

(Signed by the Governor 6/8/2012)

This act expands the information health insurance carriers must provide to covered persons or their authorized representatives, upon request, when they make an adverse determination (e.g., deny coverage), both in the initial determination and any review of this determination. It requires carriers to provide copies of the information within one calendar or five business days of the request, depending on the circumstances of the case.

By law, health carriers must file annual reports with the insurance commissioner that include a certification that they are complying with the law's requirements regarding grievance procedures. The act extends this provision to cover the requirements it adds. It requires the commissioner to adopt regulations regarding the provision of copies.

Health carriers must comply with the act's provisions and implementing regulations and ensure that utilization review entities with which they contract also do so.

The act applies to any:

1. carrier offering a health benefit plan that provides or performs utilization review, including prospective, concurrent, or retrospective review benefit determinations and
2. utilization review company or designee of a carrier that performs utilization review on the carrier's behalf, including prospective, concurrent, or retrospective review benefit determinations.

The act does not apply to self-insured plans covered by the federal Employee Retirement Income Security Act (ERISA) or plans that provide health care services solely for workers' compensation benefits.

EFFECTIVE DATE: October 1, 2012

INITIAL DETERMINATION

By law, a carrier must promptly provide a covered person and, if applicable, his or her representative, with a notice of an adverse determination. The notice can be in writing or electronic. Under prior law, the notice had to state that the covered person or representative could receive, upon request, access to and copies of all documents, records, and other information relevant to the benefit request. The act expands this requirement to include evidence and communications, and specifies that it applies to information regarding, rather than relevant to, the request. By law, the carrier must provide this information free of charge.

The act requires that, at the request of the covered person or representative, the carrier provide him or her, free of charge, copies of all documents, communications, information, and evidence, including citations to any medical journals, regarding the covered person's benefit request that is the subject of the adverse determination that were (1) not submitted by the covered person or his or her representative and (2) available to the carrier or the utilization review entity that made the adverse determination when it was made.

The act requires the carrier to provide the copies by fax, electronic means, or any other expeditious method within one calendar day after it receives a request in the case of an adverse determination of an urgent care request. It requires the carrier to provide the copies within five business days after it receives a request in the case of an adverse determination of a non-urgent care request.

Internal Reviews

Adverse Determinations Based on Medical Necessity

By law, carriers must review adverse determinations at the request of the covered person or his or her representative. In cases based in whole or in part on medical necessity, before issuing a decision the carrier must provide the covered person or representative, free of charge, any new or additional (1) evidence relied upon and (2) scientific or clinical rationale the carrier used in connection with the grievance. The act additionally requires the carrier to provide any related documents, communications, or information. The carrier must provide the required information by fax, electronic means, or any other expeditious method available. By law, under expedited review, all necessary information must be transmitted by telephone or the methods listed above.

By law, the carrier must notify the covered person and, if applicable, his or her representative, of its decision following a review of its determination. Under prior law, if the decision upheld the

adverse determination, the notice had to state that the covered person could receive, upon request, access to and copies of all documents, records, and other information relevant to the determination. The act expands this to require that the notice state that the covered person can obtain copies of all communications, and other information and evidence regarding the adverse determination that were not previously provided to the covered person or representative. By law, the carrier must provide these copies free of charge.

The act requires carriers, upon the request of the covered person or representative, to provide free of charge to him or her copies of all documents, communications, information, and evidence, including citations to any medical journals, if applicable, regarding the adverse determination or the final adverse determination, as applicable, that were not (1) submitted by the covered person or his or her representative and (2) previously provided by the carrier.

The carrier must provide these copies by fax, electronic means, or any other expeditious method within five business days after the carrier receives a request regarding a final adverse determination of a prospective, concurrent, or retrospective review.

But the carrier must provide these copies using these methods within one calendar day after it receives a request regarding a final adverse determination regarding:

1. an expedited review request, an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility;
2. a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that this care, service, or treatment would be significantly less effective if not promptly initiated; or
3. a medical condition for which the period for completing an expedited internal review of a grievance involving the adverse determination would seriously jeopardize the covered person's life or health or would jeopardize his or her ability to regain maximum function.

Adverse Determinations Based on Other Rationales

By law, carriers must establish procedures for reviewing grievances of adverse determinations that are not based on medical necessity, and the review decision must refer to evidence or documentation used as the basis for the decision. The act additionally requires the decision to refer to the relevant communications and information.

For decisions upholding an adverse determination, the act also requires that the decision include a statement that the covered person may receive from the carrier, free of charge and upon request, reasonable access to, and copies of, all documents, communications, information, and evidence regarding the subject of the final adverse determination.

Upon this request, the carrier must provide copies of the same information as described above with regard to determinations made on the basis of medical necessity. It must do so within five business days after it receives a request regarding a final adverse determination.

But the carrier must provide these copies using these methods within one calendar day after it receives a request regarding a final adverse determination regarding:

1. an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility or
2. a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that this care, service, or treatment would be significantly less effective if not promptly initiated.

EXTERNAL REVIEWS

By law, when the carrier sends a notice of an adverse determination or final adverse determination, it must disclose that the covered person or representative can seek an external review. The act requires the disclosure to state that the covered person or his or her representative may request, free of charge, copies of all documents, communications, information, and evidence regarding the adverse determination or the final adverse determination that were not previously provided to him or her.

Upon this request, the carrier must provide copies of the same information as described above with regard to determinations made on the basis of medical necessity. It must do so by the deadlines described above for determinations based on rationales other than medical necessity.

Acts of Direct Interest to the Insurance Department
Financial Regulation/Business Office

Public Act 12-2, June 12, 2012 Special Session - Sections 134 to 137 (Senate Bill 501)
An Act Implementing Certain Provisions Concerning Government Administration
(Signed by the Governor 6/15/2012)

Section 134 to 137—Exempting Certain Associations from the Insurance Statutes

The act exempts federally tax-exempt organizations that primarily provide insurance to veterans and their dependents from most Connecticut insurance laws. To qualify for a federal tax exemption, such an organization must:

1. have a principal purpose of providing insurance and other benefits to veterans or their dependents,
2. have more than 75% of its members be past or present members of the U. S. armed forces, and
3. be an association organized before 1880 (Internal Revenue Code § 501(c)(23)).

The act requires such organizations to file financial statements with the insurance commissioner annually by May 1 and pay a \$10 filing fee for each. The commissioner, when he deems it necessary, may require the organizations to file statements quarterly or more frequently.

Under the act, if the commissioner determines that such an organization has not maintained qualified assets sufficient to meet its liabilities and minimum capital and surplus requirements as determined by the commissioner, he may order the organization to increase its capital and surplus. If the organization is unable to do so, the commissioner may order it to stop assuming additional liabilities in Connecticut until it can meet the capital and surplus requirements.

The act also makes technical changes.

EFFECTIVE DATE: July 1, 2012

Section 136—Fraternal Benefit Societies' Late Filing Fee

By law, fraternal benefit societies must file financial statements with the insurance commissioner annually by March 1. The act increases, from \$100 to \$175 per day, the fee a society must pay if it fails to file a complete statement on time. It allows the commissioner to waive the late filing fee if (1) the society cannot file on time because the governor of its domiciliary (home) state proclaims a state of emergency that prevents it from filing the statement or (2) the society's domiciliary state's insurance regulator has allowed it to file the statement late.

EFFECTIVE DATE: July 1, 2012

Public Act 12-1, June 12, 2012 Special Session - Sections 214 and 215 (House Bill 6001)
An Act Implementing Provisions of the State Budget for the Fiscal Year Beginning July 1, 2012.

(Signed by the Governor 6/15/2012)

Sections 214 and 215—Childhood Immunization Insurance Assessment

Assessment Application

By law, DPH operates a state childhood immunization program, under which, and within available appropriations, the department must provide vaccines at no cost to participating health care providers. The program is funded by a “health and welfare” assessment on the state's health and life insurers. Under current law, the insurance assessment applies to all domestic health insurers specified in law. The bill applies the assessment only to those domestic health insurance companies and HMOs that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services. It also excludes life insurers from the assessment and extends the assessment to (1) licensed third-party administrators (TPA) that provide administrative services for self-insured health benefit plans and (2) domestic insurers exempt from TPA licensure who administer self-insured health benefit plans (hereafter called “exempt insurer”). TPAs and exempt insurers must pay the assessment on behalf of the health benefit plans they administer.

Reporting Requirement

The bill requires each health insurer, HMO, TPA, and exempt insurer to annually report by September 1st to the insurance commissioner on 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 the types of coverage listed above. This number must exclude lives enrolled in (1) Medicare, (2) Department of Social Services medical assistance programs, (3) workers' compensation insurance, or (4) Medicare Part C plans.

Any individual or entity that fails to file this 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.

Assessment Determinations

The bill requires the insurance commissioner, by each November 1 instead of October 1, to annually determine each insurer's assessment for the following year. Under the bill, 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 (the Office of Policy and Management determines the appropriation annually in consultation with DPH). To determine the factor, the commissioner must divide the appropriation by the total number of reported lives. Under current law, the assessment is a percentage of the appropriation determined by each insurer's share of health and life insurance premiums and subscriber charges.

The bill requires the insurance commissioner, by each December 1 instead of November 1, to annually provide each assessed entity with a statement of its proposed assessment. The assessment must be paid to the department by February 1 annually. Under existing law, any insurance company or HMO aggrieved by the assessment can appeal to Superior Court, which the bill extends to TPAs and exempt insurers.

EFFECTIVE DATE: July 1, 2012

Public Act 12-1, June 12, 2012 Special Session - Sections 216 and 217 (House Bill 6001)
An Act Implementing Provisions of the State Budget for the Fiscal Year Beginning July 1, 2012.

(Signed by the Governor 6/15/2012)

Sections 216 and 217—Captive Insurers

PA 11-1, October Special Session, revised and expanded the laws governing captive insurance companies (i.e., captives), which are wholly owned subsidiaries of other companies that formed the captives to insure all or part of the other companies' risks. It created a separate, nonlapsing captive insurance regulatory and supervision account for depositing Insurance Department fees and assessments related to captives and 11% of captive premium taxes.

The bill eliminates the account, requires the revenue to be deposited in the Insurance Fund instead, and makes conforming technical changes. It also limits the statutory limits on captives' risks to risk retention groups, a type of captive insurer formed under the federal Products Liability Risk Retention Act, instead of all captives.

EFFECTIVE DATE: July 1, 2012, with the provisions eliminating the captive insurance regulatory and supervision account applying to calendar years beginning on or after January 1, 2012.

Acts of Direct Interest to the Insurance Department
Legal Division

Public Act 12-92 (Senate Bill 27)

An Act Transitioning the Regulations of Connecticut State Agencies to an Online Format
(Signed by the Governor 6/8/2012)

This act requires that state agency regulations be posted online, rather than published in the *Connecticut Law Journal*, making them available to the public on the Office of the Secretary of the State's and regulating agency's Internet websites. It establishes the same requirement for notices of proposed regulations and their accompanying documents.

The act requires the Office of Policy and Management (OPM) secretary to seek the necessary licensing agreements to permit the online posting of regulations containing codes or standards for which a third party holds the intellectual property rights. It requires agencies to post online (1) their policy manuals and guidance documents and (2) policies that have been implemented while in the process of being adopted in regulation form.

Lastly, the act creates an 11-member Regulation Modernization Task Force to develop an implementation plan for publishing regulations online and makes technical and conforming changes.

EFFECTIVE DATE: July 1, 2013, except that the (1) task force provision and the requirement to seek licensing agreements are effective upon passage and (2) requirements concerning notices of intent are applicable to regulations noticed on and after July 1, 2013.

Sections 1 & 2—NOTICE REQUIREMENTS

Notice of Intent

By law, agencies may be authorized or required to adopt regulations. They must provide at least 30 days' notice of their intent to adopt proposed regulations. When a public act requires an agency to adopt regulations, the agency must provide the notice within five months after the passage of the act requiring adoption or by the time specified in the act. The act maintains these deadlines but establishes online posting requirements.

For regulations noticed on and after July 1, 2013, the act requires that the secretary of the state post the notice, rather than the *Connecticut Law Journal* publish it. The secretary must post the notice and its accompanying documents on her office's website within five days after receiving them from the agency. She must also provide electronic notification to any person who has requested notification of regulation-making proceedings.

The act requires agencies to post the notice and accompanying documents on their websites. They must also give electronic notice to the legislature's committees of cognizance for the regulation's subject matter at least 30 days in advance (prior law did not specify a deadline). Additionally, the act changes the deadline by which an agency must prepare a fiscal note regarding the regulations. The new deadline is 30 days before adopting the proposed regulation, rather than the date of publication in the *Connecticut Law Journal*.

Under the act, any agency that fails to post notice of intent to adopt required regulations by the applicable deadline must explain its reasons in an electronic, rather than written, statement to the governor, legislative committee of cognizance of the regulation's subject matter, and Legislative Regulation Review Committee.

The act requires agencies, after deciding to proceed with a proposed regulation or alter its text, to post to their own websites and submit to the secretary for posting on her office's website (1) the proposed regulation's final wording, (2) supporting reasons, and (3) opposing arguments and why they were rejected. Agencies must do this at least 20 days before submitting the proposed regulation to the Legislative Regulation Review Committee. If an agency fails to submit the text of the proposed regulations to the Regulation Review Committee within 180 days of posting the notice of intent, it must submit to the committee an electronic, rather than written, statement of its reasons for failing to do so.

By law, agencies must provide electronic or paper copies of proposed regulations and notices upon request. The act prohibits agencies from charging a fee for electronic copies. It requires agencies to provide the notices and copies of the proposed regulation 30 days in advance to people who have requested it. Prior law did not specify a deadline.

Other Notices

By law, an agency may propose, without prior notice, (1) technical amendments to regulations when necessary to conform to certain changes or (2) a repeal of a regulation if the authorizing statute is repealed. The act requires the agency to post to its website any such proposed technical amendments or repeals.

Sections 4, 6 & 7—APPROVED REGULATIONS

Submission to the Secretary

By law, regulations must be approved by the attorney general and the Legislative Regulation Review Committee. Prior law required agencies to submit two certified paper copies of the approved regulations to the Office of the Secretary of the State. The act instead requires agencies to submit one certified and one electronic copy to the secretary along with a statement from the department head certifying that the electronic version is a true and accurate copy of the approved regulation. The act authorizes the secretary to adopt regulations specifying the format agencies must use to submit electronic regulations and documents.

Regulation Effective Date

Under prior law, with some exceptions, regulations became effective when an agency filed them with the secretary. Under the act, regulations become effective when the secretary publishes them online, which she must do within five calendar days after the agency's filing. The act specifies that emergency regulations are effective upon electronic submission to the secretary. It eliminates the requirement that, before becoming enforceable, agency regulations must be published in the *Connecticut Law Journal*.

The act designates the online regulations posted by the secretary as the “official version” of the regulations of state agencies for “all purposes, including all legal and administrative proceedings.

It requires agencies to provide or make available for inspection, if requested, paper copies of regulations and other written policy statements and agency forms and instructions.

Sections 6-8— PUBLISHED REGULATIONS

The act removes the:

1. duties of the Commission on Official Legal Publications (COLP) to publish (a) the semiannual compilation of all adopted state agency regulations and (b) a monthly update of approved regulations in the *Connecticut Law Journal*;
2. requirement to make published regulations available to state agencies and officials for free and to others for sale;
3. requirement that published regulations be included in each state law library's reference collection; and
4. ability to omit from the compilation emergency regulations and those that are too expensive or unduly cumbersome to publish.

The act requires the secretary to post the compilation of regulations, including emergency regulations, online in a manner easily accessible to, and searchable by, the public. She must update the compilation at least quarterly, and it must include website links to any regulation incorporated by reference. She must also include in the compilation a website link, if available, to information about any omitted regulations. By law, she may omit from the compilation regulations incorporated by reference that are (1) available from a federal agency or a government agency in another state and (2) to which a third party holds the intellectual property rights. (The act specifies that she may do this only until the OPM secretary obtains the necessary licensing agreements, as described below.)

Proprietary Regulations

In practice, non-state entities hold the intellectual property rights to several codes and standards that are incorporated by reference into state agency regulations (e. g. , the State Building Code and the State Fire Safety Code). The act requires the OPM secretary to seek the necessary licensing agreements from the publishers of these codes and standards to permit them to be posted online by the secretary of the state.

Sections 9-12— AGENCY POLICIES

Policy Manuals and Guidance Documents

The act requires any state agency that has written a manual or guidance document to post it on its website. It exempts from this requirement anything that is (1) protected from disclosure under state or federal law or (2) exempt from disclosure under the Freedom of Information Act. Additionally, it specifically requires the Department of Social Services (DSS) to post to its website its medical services, public assistance, and community services manuals.

Policies Awaiting Adoption in Regulation Form

By law, DSS must adopt as regulations policies necessary to conform to certain federal or joint federal and state program requirements. The law allows DSS to operate under such policies while in the process of adopting them in regulation form. Before implementing the policies, the act requires DSS, like other agencies, to post them to its website and electronically submit them

to the secretary of the state for online posting. Unlike other agencies, the act retains the requirement that these DSS notices of intent appear in the *Connecticut Law Journal*.

The act also extends the online posting requirement to all agencies that adopt interim policies or procedures while the policies or procedures are in the process of being adopted in regulation form. Under the act, these policies and procedures are not effective unless the agency (1) posts them on its website, (2) electronically submits them to the secretary for posting online, and (3) complies with the authorizing statute's other requirements, if applicable. Any of these policies or procedures in effect on July 1, 2013 must be posted on the agency's website and submitted to the secretary by October 1, 2013. There is no deadline for the secretary to post them. When the superseding regulations take effect, the agency must notify the secretary, who must then remove the policy or procedure from the secretary's website.

Section 15—REGULATION MODERNIZATION TASK FORCE

The act establishes an 11-member gubernatorially appointed task force to develop a plan that ensures, by July 1, 2013, that Connecticut state agency regulations are available to the public in an accessible online format. The governor must (1) make the appointments within 30 days of the act's passage, (2) select the chairperson, and (3) fill any vacancy. The act requires the Department of Administrative Services (DAS) to provide administrative staff support. The task force must consult with the secretary of the state and either the state librarian or public records administrator.

By January 1, 2013, the task force must submit a plan to the governor and Regulation Review Committee that ensures state agency regulations are easily accessible to the public in an online format by July 1, 2013. The task force terminates on January 1, 2013 or when it submits its plan, whichever is later.

At a minimum, the plan must:

1. identify the hardware and software needed to transfer regulations to an online format;
2. recommend the appropriate state agency to supervise maintenance of the online system;
3. describe the necessary staff training for using and maintaining the system;
4. describe the anticipated amount of additional work and responsibilities required to create and maintain the system;
5. describe the reduction in workload and costs that are anticipated with the system;
6. estimate the cost to implement and maintain the system, with recommendations on how the state can recover it; and
7. recommend additional legislation that may be necessary to facilitate the transition to publishing regulations in an online format.

The act authorizes the task force to request bond funds through DAS to pay a consultant for advice on the technical aspects of implementing and maintaining an online system for regulations. The Legislative Commissioners' Office, COLP, and all executive branch agencies must cooperate and provide information the task force needs.

Acts of Interest to the Insurance Department

Public Act 12-3 (House Bill 5303)

An Act Concerning the Exemption from Disclosure of Certain Addresses under the Freedom of Information Act

(Signed by the Governor 3/6/2012)

Prior law prohibited any state or municipal public agency from disclosing, under the Freedom of Information Act (FOIA), the home addresses of certain public officials and employees (see BACKGROUND for covered individuals). This act narrows the prohibition. Specifically, it (1) permits certain municipal and election-related documents to be disclosed without address redactions and (2) limits to a covered individual's employing agency, instead of all public agencies, the requirement to automatically keep his or her residential address confidential in certain documents.

It allows a covered individual to request address confidentiality from public agencies other than his or her employer and establishes procedures for these agencies to follow when receiving a FOIA request for certain records containing that individual's home address.

The act prohibits public agencies, public officials, or employees of public agencies from being penalized for violating the disclosure prohibition unless the Freedom of Information Commission (FOIC) finds a willful and knowing violation. It requires the Government Administration and Elections (GAE) Committee to establish an advisory committee to study possible alternatives to disclosing certain public records without redaction.

Lastly, the act requires the Labor Department to create, within available appropriations, a guide that instructs covered individuals on how to exercise their rights under the act and protect their home addresses from disclosure. The department must create the guide within 60 days after the act's passage (by May 5, 2012) and post it on its website.

EFFECTIVE DATE: Upon passage, except the provisions (1) limiting the automatic disclosure prohibition to the employing agency, (2) authorizing nondisclosure requests to non-employing agencies, and (3) establishing procedures for non-employing agencies to follow, are effective June 1, 2012.

DISCLOSURE OF HOME ADDRESSES

Under prior law, state and municipal agencies receiving FOIA requests for public documents containing covered individuals' home addresses were required to redact their addresses before disclosing the documents. Under the act, the disclosure prohibition does not apply to home addresses of covered individuals contained in (1) documents eligible to be recorded in municipal land records; (2) any list required by the state's election laws (e. g. , preliminary and final voter registry lists, petition forms, logs of absentee ballot applications); or (3) municipal grand lists.

Beginning June 1, 2012, the act further limits the automatic prohibition on disclosure of home addresses to personnel, medical, or similar files held by a covered individual's employing agency

only. Because federal officials and employees are protected under the law, the legal effect of this provision is unclear with respect to them, since the state has no jurisdiction over federal agencies.

Under the act, covered individuals who want an agency other than their employing agency to keep their home addresses confidential must submit a written request to that agency. An individual submitting such a request must provide the public agency with his or her business address. For such an individual, a non-employing agency must redact his or her home address only from (1) records provided in response to a request that specifically names the covered individual, (2) an existing list derived from a readily accessible electronic database, and (3) any list that the agency voluntarily creates in response to a request for disclosure. The act allows disclosure of a covered individual's residential address in any other type of record.

Table 1 describes the act's procedures for public agencies to follow when receiving a FOIA request for records containing the home address of a covered individual who has submitted a nondisclosure request.

Table 1: Responding to Requests for Home Addresses of Covered Individuals Who Have Submitted Nondisclosure Requests

<i>Type of Request</i>	<i>Required Response</i>
One that specifically names a covered individual	Agency must make a copy of the record and redact the covered individual's address prior to disclosure
For (1) an existing list derived from a readily accessible electronic database or (2) any list that the agency voluntarily creates in response to a request for disclosure	Agency must make a reasonable effort to redact any covered individual's address before disclosing the list

The act prohibits public agencies, public officials, or employees of public agencies from being penalized for violating the disclosure prohibition unless the FOIC finds that the violation was willful and knowing. Under the act, complaints of such violations must be made to the FOIC.

The FOIC must hold a hearing in accordance with the Uniform Administrative Procedure Act for complaints it receives. However, it may dismiss a complaint without a hearing if, after examining it and construing all allegations most favorably to the complainant, it finds that there was not a willful and knowing violation. If the FOIC finds a willful and knowing violation, it may impose a civil penalty of between \$20 and \$1,000 against the agency, official, or employee.

The act prohibits an individual from suing a public agency or its officials or employees for violating the disclosure prohibition.

ADVISORY COMMITTEE

The act requires the GAE Committee to establish an advisory committee to study whether there are alternatives to permitting the disclosure of certain public records without redaction. The

chairpersons of the GAE Committee must appoint an unspecified number of advisory committee members and designate two of them as the chairpersons.

The act requires the GAE Committee's administrative staff to serve as the advisory committee's administrative staff. The advisory committee must submit its findings and recommendations to the GAE, Planning and Development, and Public Safety committees by January 1, 2013. The advisory committee terminates when it submits its report or on January 1, 2013, whichever is later.

BACKGROUND

Commissioner of Public Safety v. Freedom of Information Commission

In *Commissioner of Public Safety v. Freedom of Information Commission*, 301 Conn. 323 (2011), the Connecticut Supreme Court held that the prohibition against disclosing certain individuals' home addresses applies to motor vehicle grand lists and their component data that the Department of Motor Vehicles provides to town assessors.

Individuals Covered by CGS § 1-217

The following public officials and employees are covered by the home address disclosure prohibition (CGS § 1-217):

1. federal court judges and magistrates;
2. Connecticut Superior and Appellate Court judges, Supreme Court justices, and family support magistrates;
3. sworn members of municipal police departments or the State Police and sworn law enforcement officers in the Department of Energy and Environmental Protection;
4. employees of the Judicial Branch and the departments of Correction and Children and Families;
5. attorneys who represent or have represented the state in a criminal prosecution;
6. attorneys who are or have been employed by the Public Defender Services Division and social workers employed by the division;
7. Division of Criminal Justice inspectors;
8. firefighters;
9. members and employees of the Board of Pardons and Paroles and the Commission on Human Rights and Opportunities; and
10. Department of Mental Health and Addiction Services employees who provide direct patient care.

Public Act 12-13 (Senate Bill 56)

An Act Concerning Critical Congenital Heart Disease Screening for Newborn Infants

(Signed by the Governor 5/8/2012)

Starting January 1, 2013, this act requires all health care institutions caring for newborn infants to test them for critical congenital heart disease, unless, as allowed by law, their parents object on religious grounds. It requires the testing to be done as soon as medically appropriate. As with existing law that requires these institutions to test newborn infants for cystic fibrosis and severe

combined immunodeficiency disease, the test for critical congenital heart disease is in addition to the state's newborn screening program for genetic and metabolic disorders. That program, in addition to screening, directs parents of identified infants to counseling and treatment.

EFFECTIVE DATE: October 1, 2012

Public Act 12-77—(Senate Bill 353)

An Act Concerning the State's Second Injury Fund

(Signed by the Governor 6/6/2012)

This act allows the Second Injury Fund to request that a workers' compensation commissioner issue an "attachment" to seize an employer's property to secure payments from the fund. This applies when (1) a person has filed a workers' compensation claim, (2) the employer has not satisfied the requirement to carry insurance or demonstrate other means of paying workers' compensation claims, and (3) it appears the situation may require payment from the Second Injury Fund (see BACKGROUND).

By law, employers are liable for any payments made from the fund, and the state can collect the money by a civil action, any means used to collect taxes, or filing a lien against the employer (CGS §§ 31-355 and -355a). By adding the ability to obtain an attachment, the act allows the fund to secure property to satisfy the employer's obligation to repay the fund. The law already allows a claimant to request an attachment against an employer who has not satisfied the workers' compensation financial requirements to secure payment of his or her claim.

The act also expands the circumstances in which the state treasurer can make a payment from the Second Injury Fund under a stipulated agreement to settle a workers' compensation claim. Previously, she could only do so when it was in the injured employee's best interests. The act also allows these payments (1) when it is in the best interests of the injured employee's dependents or (2) for claims by an employer or insurer regarding death benefits for dependents, cost of living adjustments for claimants suffering long-term total disability, or cases of multiple employers where the Second Injury Fund makes payments to enable the employee to receive full benefits.

EFFECTIVE DATE: October 1, 2012

BACKGROUND

Second Injury Fund

This fund provides workers' compensation insurance coverage to workers whose employers failed to provide it. By law, the fund's custodian can also sue or join an employee's lawsuit.

Public Act 12-81 - Sections 7 and 8 (House Bill 5164)
An Act Concerning Revisions to the Motor Vehicle Laws
(Signed by the Governor 6/8/2012)

Section 7 & 8 —DEALER & REPAIRER FEES

By law, licensed motor vehicle repairers, new and used motor vehicle dealers, and motor vehicle rental companies, and applicants for such licenses, must furnish cash or surety bonds. Repairers and used and new motor vehicle dealers must also furnish proof of financial responsibility (insurance). The act requires the commissioner to impose a \$50 fee on licensees who fail to continuously meet these bond and financial responsibility requirements. The fee is in addition to license suspension or revocation penalties and civil penalties of up to \$1,000 per violation to which the licensees are subject under existing law (CGS § 14-64).

EFFECTIVE DATE: October 1, 2012

Public Act 12-101—(Senate Bill 376)
An Act Concerning the Coastal Management Act and Shoreline Flood and Erosion Control Structures
(Signed by the Governor 6/8/2012)

This act makes several changes in the Coastal Management Act (CMA) and laws regulating certain activities in the state's tidal, coastal, or navigable waters. Among other things, it:

1. modifies CMA's general goals and policies to consider (a) private property owners' rights when developing, preserving, or using coastal resources and (b) the potential impact of a rise in sea level when planning coastal development to minimize certain needs or effects (§ 1);
2. expands the list of land uses that can be protected by structural solutions under certain circumstances to include (a) cemetery and burial grounds and (b) inhabited structures built by January 1, 1995 (§ 1);
3. requires a municipal zoning commission to approve a coastal site plan for a shoreline flood and erosion control structure under certain circumstances (§ 3);
4. requires a municipal zoning commission or the Department of Energy and Environmental Protection (DEEP) commissioner to propose structure alternatives or mitigation measures and techniques if they deny a shoreline flood and erosion control structure application for certain reasons (§ 1); and
5. replaces the statutory definition of “high tide line” with one for “coastal jurisdiction line” (§§ 4-8).

The act also requires the Office of Policy and Management (OPM) to consider coastal erosion when revising the state Plan of Conservation and Development after October 1, 2012. It authorizes establishing certain programs and preparing a study related to shoreline protection and management.

EFFECTIVE DATE: October 1, 2012, except for the provision concerning coastal site plan approval for shoreline flood and erosion control structures, which is effective upon passage.

Section 2 — DEFINITION OF RISE IN SEA LEVEL

The act defines a “rise in sea level” under the CMA as the average of the most recent equivalent per-decade rise in the state's tidal and coastal waters surface level, as documented for annual, decadal, or centenary periods at any state site specified in National Oceanic and Atmospheric Administration (NOAA) online or printed publications.

Section 1 — COASTAL MANAGEMENT ACT GOALS AND POLICIES

By law, the CMA sets general goals and policies to balance development and protection of the state's coastal resources. The act adds to these goals and policies consideration of private property owners' rights when developing, preserving, or using coastal resources. It also adds consideration of the potential impact of a rise in sea level, in addition to coastal flooding and erosion patterns as required under existing law, when planning coastal development. Such planning consideration must minimize shoreline armoring to protect future new development. Existing law already requires it to (1) minimize damage to and destruction of life and property and (2) reduce public expense to protect future development.

The CMA also provides policies for federal, state, and local agencies to follow when regulating land and water resources in the coastal boundary. Under prior law, CMA policy allowed structural solutions to protect certain facilities, uses, or inhabited structures when (1) necessary and unavoidable; (2) there is no feasible, less environmentally damaging alternative; and (3) all reasonable mitigation measures and techniques have been provided. The act extends this policy to protect (1) cemetery and burial grounds and (2) inhabited structures built by January 1, 1995.

By law, CMA policy promotes nonstructural solutions to flood and erosion problems when managing coastal hazard areas unless structural solutions are unavoidable and needed to protect, among other things, existing inhabited structures built before January 1, 1980. The act expands this exception to include inhabited structures built by January 1, 1995.

The act specifies that, for the purposes of CMA's goals and policies, “feasible, less environmentally damaging alternative” includes such things as (1) relocating an inhabited structure to a landward location; (2) elevating an inhabited structure; (3) restoring or creating a dune or vegetated slope; or (4) living shoreline techniques that use a variety of structural and organic materials to protect the shoreline and maintain or restore coastal resources and habitat, like tidal wetland plants, submerged aquatic vegetation, coir (coconut) fiber logs, sand fill, and stone.

Sections 1 and 3 — SHORELINE FLOOD AND EROSION CONTROL STRUCTURES

Definition

The act specifically excludes from the definition of “shoreline flood and erosion control structure” any activity that has the primary purpose or effect of restoring or enhancing tidal wetlands, beaches, dunes, or intertidal flats, such as living shoreline projects. By law, such a structure controls flooding or erosion from tidal, coastal, or navigable waters, and includes breakwaters, bulkheads, groins, jetties, revetments, riprap, seawalls, and placing concrete, rocks, or other significant barriers to flood water flows or sediment movement along the shoreline. The law, unchanged by the act, already excludes certain additions, reconstructions, changes, or adjustments to a walled and roofed building.

Coastal Site Plan Approval

By law, the CMA requires coastal site plan reviews for certain activities at least partially in the coastal boundary and landward of the mean high water mark. A coastal site plan for a shoreline flood and erosion control structure must be filed with a municipal zoning commission to determine conformity with municipal zoning regulations and certain state statutory requirements. A shoreline flood and erosion control structure applicant must obtain any necessary DEEP approval for conducting a regulated activity in the state's tidal, coastal, or navigable waters waterward of the coastal jurisdiction line (previously the high tide line).

The act requires a municipal zoning commission to approve a coastal site plan for a shoreline flood and erosion control structure if the record demonstrates and the commission makes specific written findings that:

1. the structure is necessary and unavoidable to protect (a) infrastructure facilities, (b) cemetery or burial grounds, (c) water-dependent uses fundamental to habitability or the property's primary use, or (d) inhabited structures or additions constructed by January 1, 1995;
2. there is no feasible, less environmentally damaging alternative; and
3. all reasonable mitigation measures and techniques are implemented to minimize adverse environmental impacts.

Alternatives, Mitigation Measures, and Techniques

Under the act, if the DEEP commissioner or a municipal commission denies a shoreline flood and erosion control structure application because (1) there may be feasible, less environmentally damaging alternatives or (2) reasonable mitigation measures and techniques were not provided, they must propose, in writing and on the record, the types of alternatives or efforts the applicant can investigate. The act specifies that this requirement does not shift the applicant's burden to (1) prove entitlement to approval or (2) present alternatives.

“Reasonable mitigation measures and techniques” include such things as (1) provisions for upland migration of on-site tidal wetlands, (2) littoral (associated with tidal water shore land) system and public beach replenishment with suitable sediment at a rate and frequency equal to the sediment removed from the site because of the proposed structure, or (3) on- or off-site removal of existing shoreline flood and erosion control structures from public or private shoreline property to at least the same extent as the shoreline area impacted by the proposed structure.

Section 4-8 — REGULATED ACTIVITY IN TIDAL, COASTAL, OR NAVIGABLE WATERS

Coastal Jurisdiction Line

The act removes the statutory definition of and references to “high tide line,” replacing it with “coastal jurisdiction line.” It defines “coastal jurisdiction line” as the location of the topographical elevation of the highest predicted tide from 1983 to 2001, based on the most recent National Tidal Datum Epoch published by NOAA and described in terms of feet of elevation above the North American Vertical Datum of 1988.

The act specifies that, for any of the state's tidal, coastal, or navigable waters upstream of a tide gate, weir, or other device that modifies tidal water flow, the coastal jurisdiction line is the elevation of mean high water found at the device's downstream location.

By law, DEEP regulates dredging, erecting structures, placing fill, and related work in state tidal, coastal, or navigable waters waterward of the coastal jurisdiction line.

Navigable Waters

The act defines “navigable waters,” for purposes of regulating certain coastal activities, as (1) Long Island Sound or any of its coves, bays, or inlets and (2) the part of any tributary, river, or stream that empties into Long Island Sound upstream to the first permanent obstruction to watercraft navigation from Long Island Sound.

Section 9 — STATE PLAN OF CONSERVATION AND DEVELOPMENT

By law, OPM must prepare the state Plan of Conservation and Development for legislative approval every five years. Starting October 1, 2012, the act requires any plan revision to (1) consider risks associated with increased coastal erosion caused by a rise in sea level, based on site topography; (2) identify impacts of such increased erosion on infrastructure and natural resources; and (3) make recommendations for siting future infrastructure and property development to minimize using areas prone to such erosion.

Section 10 — SHORELINE PROGRAMS AND STUDY

Pilot Program

The act authorizes the DEEP commissioner, within available appropriations, to establish a pilot program to encourage innovative and low-impact approaches to (1) shoreline protection and (2) sea level rise adaptation. These approaches may include living shoreline techniques to protect the shoreline and maintain or restore coastal resources and habitat, with various structural and organic materials such as (1) tidal wetland plants, (2) submerged aquatic vegetation, (3) coir fiber logs, (4) sand fill, and (5) stone.

It allows the DEEP commissioner to (1) solicit proposals for site-specific pilot projects using the above approaches and (2) offer technical assistance for the projects. If a proposed project involves tidal wetlands or tidal, coastal, or navigable waters waterward of the coastal jurisdiction line, the DEEP commissioner can only select up to three such projects each year to receive expedited permission to conduct certain maintenance activities. By law, such activities include (1) substantial maintenance or repair of existing structures, fill, obstructions, or encroachments; (2) certain maintenance dredging; (3) removal of derelict structures or vessels; and (4) temporary structure placement for water-dependent uses, among other things (CGS § 22a-363b).

Science and Engineering Capacity Program

The act also authorizes the University of Connecticut and the Connecticut State University System to work with other academic institutions and federal and state agencies to seek funds and establish a program to develop and maintain state science and engineering capacity to support shoreline planning and management, to enhance coastal community resilience to coastal hazards and sea level rise. They can do so within available appropriations.

Shoreline Management Study

The act authorizes the DEEP commissioner, within available appropriations and in conjunction with academic institutions, nongovernmental organizations, or federal agencies, to seek funds for and prepare a shoreline management study. The study's purpose is to enhance coastal community resilience to coastal hazards and sea level rise, particularly in areas significantly impacted by coastal storms.

BACKGROUND

Coastal Boundary

The “coastal boundary” is the furthest inland of (1) the 100-year-frequency coastal flood zone, (2) a 1,000-foot setback from the mean high-water mark, or (3) a 1,000-foot setback from the inland boundary of the tidal wetlands (CGS § 22a-94(b)).

Related Act

PA 12-100 also adds cemetery and burial grounds to the list of land uses that can be protected by structural solutions in the coastal boundary.

Public Act 12-106 (House Bill 5414)

An Act Concerning the Elimination of the Interest Rate Floor for Tax and Insurance Escrow Accounts

(Signed by the Governor 6/8/2012)

Prior law required the interest rate on tax and insurance escrow accounts to be at least the average savings deposit interest rate paid by insured commercial banks published in the Federal Reserve Board Bulletin in November of the previous year (i.e., deposit index) but not less than 1.5%. This act retains the deposit index method for calculating the interest rate but eliminates the minimum 1.5% interest rate. (The 2012 deposit index is 0.16%.)

By law, state banks and trust companies, national banking associations, state or federally chartered savings and loan associations, savings banks, insurance companies, and other mortgagee or mortgage servicing companies must pay interest on these accounts.

EFFECTIVE DATE: October 1, 2012

Public Act 12-148 (Senate Bill 23)

An Act Enhancing Emergency Preparedness and Response

(Signed by the Governor 6/15/2012)

This act requires the Public Utilities Regulatory Authority (PURA) to initiate a proceeding to (1) review electric and gas company emergency preparation and service restoration practices, infrastructure adequacy, and coordination efforts; (2) establish electric and gas company emergency performance standards for the companies; and (3) identify the most cost-effective levels of electric company tree trimming and system hardening needed to achieve maximum

system reliability and minimize outages. It requires PURA to review the companies' performance after an emergency and issue orders to enforce the standards. It also allows PURA to issue civil penalties for violations. In addition, the companies must submit annual reports on their performance in emergencies.

The act requires PURA to open a proceeding to establish standards for restoring intrastate telecommunications under certain circumstances after an emergency. It also requires telecommunications companies to issue credits to customers who lose service under certain circumstances.

The act also:

1. requires the Department of Energy and Environmental Protection (DEEP), in consultation with the utility companies, the Department of Transportation (DOT), the Department of Emergency Services and Public Protection (DESPP), and an association of municipalities, to develop, by January 1, 2013, a procedure for expedited road clearing for public safety personnel after an emergency;
2. increases the frequency with which private and municipal utility companies must file emergency service restoration plans;
3. requires certain telecommunications companies to provide liaisons to electric company emergency response centers under certain circumstances;
4. requires cell phone service providers to report on the backup power generation capabilities of their cell towers;
5. establishes a pilot program to fund infrastructure (micro-grids) for onsite electricity generation for critical facilities;
6. increases communication between DOT, PURA, municipalities, and utilities to coordinate roadwork and utility line undergrounding; and
7. requires PURA to study the feasibility of creating a program to reimburse residential customers for food and medications lost due to power outages.

It expands the scope of the state's civil preparedness and training requirements by requiring all private utility companies, including electric, gas, telephone, water, and cable TV companies, to comply with the state's comprehensive civil preparedness plan. It also requires all state departments, offices, and agencies to participate in civil preparedness planning, training, and exercises when directed to do so by the DESPP commissioner.

The act also expands the scope of activities for which the DEEP commissioner can issue temporary authorizations.

By law, the Office of Consumer Counsel (OCC) advocates for consumer interests in matters regarding the regulated utility companies. The act expands OCC's charge to include rates and related issues, ratepayer-funded programs, and matters related to the utilities' reliability, service quality, infrastructure maintenance, and operations.

EFFECTIVE DATE: Upon passage, except for the provisions regarding civil preparedness planning and training, which are effective July 1, 2012.

STORM PREPARATION AND RESPONSE

The act requires PURA to initiate a proceeding to establish industry specific standards for acceptable performance by electric and gas companies in an emergency (hurricane, tornado, storm, flood, high water, wind-driven water, snowstorm, drought, fire, explosion, or enemy attack). The standards must (1) protect public health and safety; (2) ensure service reliability; (3) prevent and minimize the number and duration of service outages; (4) facilitate restoration after outages; and (5) identify the optimum levels of tree trimming and system hardening, including putting equipment underground, to maximize system reliability and minimize service outages. PURA must submit a report on the standards and any necessary legislation to the Energy and Technology Committee by November 1, 2012.

PURA Review

In preparing the standards, the act requires PURA to review and analyze:

1. each electric and gas company's current restoration practices following an emergency, including (a) damage and outage estimates made before an emergency; (b) damage and outage assessments made after an emergency; (c) restoration management after an emergency, including any access to other restoration resources provided by regional and reciprocal aid contracts; (d) planning for at-risk and vulnerable customers; (e) communication policies with state and local officials and customers, including individual restoration estimates and the timeliness and usefulness of the estimates; and (f) the need for mutual assistance during an emergency;
2. the adequacy of each company's infrastructure, facilities, and equipment, including whether the company (a) follows standard industry practices for their operations and maintenance and (b) can access adequate replacement equipment during an emergency;
3. coordination efforts between electric companies, telecommunications companies, and cable TV companies, including pre-emergency planning;
4. each electric company's tree trimming policies, including (a) amounts spent on tree trimming since its last rate case; (b) the average length of outages caused by falling trees and limbs; (c) how expanding the trimming zone around the company's distribution lines would affect ratepayers, infrastructure damage, and equipment, and decrease the frequency and length of outages; (d) the percentage of outages during Hurricane Irene and the October 2011 snowstorm that were caused by falling trees and limbs outside current trim areas, based on an analysis of the extent and effectiveness of prior tree trimming; and (e) appropriate standards for roadside tree care, vegetation management practices in utility rights-of-way, "right tree-right place," and any other tree maintenance standards recommended by the State Vegetation Management Task Force; and
5. any other policies, practices, or information relevant to the review.

Electric & Gas Company Performance Standards

The act requires PURA to establish minimum performance standards for an electric or gas company's preparation and service restoration during an emergency in which more than 10% of its customers are without service for more than 48 hours. The standards must include requirements for:

1. minimum staffing and equipment levels for each company, based on the size of its customer base and the nature of its infrastructure;
2. recovery and restoration targets based on outages affecting over 10%, 30%, 50%, and 70% of a company's customers;

3. a communication plan between the company and its customers that includes communications during non-business hours;
4. safety standards for company employees, mutual aid crews, and private contractors;
5. the filing of mutual aid agreements (which the act exempts from disclosure under the Freedom of Information Act) and an assessment of each company's ability to rely on assistance from other regional utilities;
6. communication and coordination protocols between companies and state and local emergency operations centers regarding emergency preparation, road clearing, and restoration priorities;
7. electric company tree trimming, cutting, and removal to reduce outages;
8. communication and coordination, in consultation with DESPP, between each company and the public, including standards for using the emergency notification system to notify the public of service restorations and possible dangerous conditions;
9. timely communications between companies and relevant state and local officials regarding emergency coordination and communication;
10. communication and coordination between appropriate electric, gas, and telephone or telecommunication companies or voice over internet protocol (VOIP) providers; and
11. operations of electric and gas company call centers.

The act requires PURA to establish any other performance standards to (1) ensure a gas or electric company's reliability during an emergency, (2) prevent outages from lasting over 48 consecutive hours and affecting over 10% of the company's customers, and (3) promote service restoration after an outage. It also allows PURA to initiate additional dockets to establish emergency performance standards for electric and gas companies if it determines that a company's changed circumstances require it.

In future rate cases, the act requires PURA to allow electric or gas companies to recover the reasonable costs they incur by maintaining or improving their infrastructure's resiliency, pursuant to plans that PURA approves, in order to meet the standards that PURA implements.

By April 15, 2013, and annually thereafter, the act requires electric and gas companies to submit an emergency response report to PURA. The report must include information and analysis regarding how the company complied with the act's emergency preparation and restoration standards in the previous year. PURA can also require any of the companies to submit a supplemental emergency response plan or implementation plan after any storm, emergency, or event that caused significant outages.

PURA Performance Review & Penalties

The act requires PURA to review each electric or gas company's performance (1) after an emergency in which over 10% of the company's customer lost service for over 48 consecutive hours or (2) at its discretion. If PURA finds that a company failed to comply with any of the act's emergency preparation and service restoration standards, or any other PURA order, it must hold a contested case hearing and issue orders to enforce the standards.

The act also allows PURA to issue civil penalties against electric or gas companies of up to \$10,000 per offense, up to a total of 2.5% of their annual distribution revenue, for noncompliance in these emergencies. In determining the penalty, the act requires PURA to

consider if it approved the company's efforts and funding allowances to meet infrastructure resiliency standards. The penalties must be paid as a credit to ratepayers and cannot be considered an operating expense that the company may recover in its rates.

Intrastate Telecommunication Restoration Standards

The act requires PURA to initiate a docket to establish standards for restoring intrastate telecommunications services following an emergency for service provided by telephone companies, certified telecommunications providers, and cable TV companies. The standards can only apply when an outage caused by an emergency (1) affects over 10% of a company's access lines for over 48 consecutive hours and (2) was not caused by the equipment, negligence, or willful act of a customer or third party.

In establishing the standards, the act requires PURA to consider:

1. the severity, extent, and duration of an emergency;
2. communication and coordination by each company with the state, municipalities, and any relevant electric company;
3. the operations of any call center operated by each company during an emergency;
4. requirements for each company to assign a representative to staff the emergency operations center of any relevant electric company;
5. service restoration;
6. the safety of the company's customers; and
7. whether restoration of intrastate telecommunications service could not be completed until commercial power was restored.

If PURA finds that a company failed to comply, the act allows it to submit a report to the Energy and Technology Committee recommending legislation to establish penalties for future noncompliance.

Telecommunications Billing Credits

To the extent allowed by federal law, the act requires telephone companies and certified telecommunications providers to issue credits to customers who lose intrastate telecommunications service during an emergency if (1) the outage lasts over 24 consecutive hours and affects over 10% of the company's access lines; (2) the outage was not caused by a commercial power outage or the equipment, negligence, or willful act of the customer or a third party; and (3) the customer notifies the company within 30 days of the end of the emergency. The credit must be prorated to reflect the portion of the billing period during which the customer was without service. The act specifically excludes cable TV companies that are already required to provide a similar customer credit under current law.

Emergency Service Restoration Plans

Prior law required private and municipal utility companies, including water companies, to file emergency service restoration plans with PURA, DESPP, and local municipalities every five years. The act instead requires these plans to be filed every two years, with the next plan due July 1, 2012, and adds VOIP providers to the utilities subject to the mandate. In addition to the items prior law required in the plans, the act requires them to include (1) communication and coordination measures with state officials, municipalities, and other private utilities and

telecommunications companies during a major disaster or emergency; (2) participation in training exercises as directed by the DESSP commissioner; and (3) responses for service outages affecting more than 10%, 30%, 50%, and 70% of customers.

Under the act, any information provided in the plans is considered confidential, not subject to the Freedom of Information Act (FOIA), and cannot be transmitted to anyone unless it is needed to comply with the act. The act requires PURA, by September 1, 2012, and biannually thereafter, to summarize the plans in a report to the Energy and Technology Committee.

Emergency Operations Center Representatives

The act requires telephone companies, certified telecommunications providers, and cable TV companies with more than 25,000 subscribers to provide a liaison to an affected electric company's emergency operations center to ensure communication and coordination during emergency response and restoration efforts. The companies must provide the liaison (1) when the governor or president declares an emergency or major disaster or (2) at the DESPP commissioner's discretion.

REPORTS ON CELL PHONE SERVICE BACKUP GENERATION

By October 1, 2012, and annually thereafter, the act requires each mobile radio (cell phone) service provider to issue a report to the Connecticut Siting Council and DESPP on its ability and plans to provide backup power to its telecommunications towers and antennae during an electricity outage. Under the act, any information provided in the reports (1) is confidential, (2) is exempt from disclosure under FOIA, and (3) cannot be transmitted to anyone else except to comply with the act's reporting requirement.

Once the initial reports have been submitted, the act requires the Siting Council, in consultation with DEEP, DESPP, and PURA, to study the feasibility of requiring backup power for telecommunications towers and antennas. The study must consider (1) federal, state, and local jurisdictional issues, including siting issues; (2) similar laws or initiative in other states; (3) the technical and legal feasibility of such requirements; (4) related environmental issues; and (5) any other issues PURA considers relevant. PURA (presumably the Siting Council) must report its findings and recommendations to the Energy and Technology Committee by January 1, 2013.

MICRO-GRID GRANT AND LOAN PILOT PROGRAM

The act requires DEEP to establish a microgrid grant and loan pilot program to support up to 65 megawatts of onsite electricity generation (the amount of power needed to serve approximately 50,000 homes) at critical facilities (i. e. , hospitals, police and fire stations, water and sewage treatment plants, public shelters, correctional facilities, municipal commercial areas, municipal centers identified by a municipality's chief elected official, or other facilities identified by DEEP). Under the act, a "microgrid" is a group of interconnected electricity users and generators that (1) is within clearly defined electrical boundaries that acts as a single controllable entity in respect to the larger electrical grid and (2) can operate as either a part of the larger grid or independent of it, in "island mode. "

The pilot program is open to municipalities, investor-owned electric companies, municipal electric companies that participate in the competitive electricity supply market (none currently

do), energy improvement districts, and private entities that propose supporting these facilities by developing micro-grid energy generation or converting existing renewable generation for micro-grid use. Eligible parties can collaborate to submit a proposal.

The program can issue up to \$15 million in total grants and loans and, to the extent possible, the awards must be evenly distributed between small, medium, and large municipalities. The grants and loans can only be used for the costs of microgrid design, engineering services, and interconnection infrastructure. The act does not specify a funding source for the program, but allows DEEP to establish a financing mechanism to leverage additional funding that could be used for purposes other than microgrid interconnection infrastructure (PA 12-189 authorizes up to \$25 million in bonds for the microgrid program).

The act requires any entity that receives a grant or loan under the program to issue an annual report on the project's status to PURA, DEEP, the OCC, and the Energy and Technology Committee for five years after receiving the funding. It also requires DEEP, by January 1, 2013, to report to the Energy and Technology Committee on other funding sources needed to expand the program and any necessary legislative changes.

It also requires DEEP, in consultation with the Connecticut Academy of Science and Engineering, to study how to provide reliable electric services to critical facilities. The study must evaluate the costs and benefits of methods, including the use of microgrids, and make recommendations identifying the most cost-effective and reliable methods. DEEP must submit its findings to the Energy and Technology Committee by January 1, 2013.

ROAD WORK COORDINATION

The act requires DOT and any municipality to notify PURA whenever they do road work (1) over five miles long or (2) in a commercial area. PURA must then notify utility companies if it determines that the road work could provide an opportunity to install, replace, upgrade, or bury any of their various infrastructure lines.

ELECTRIC CUSTOMER REIMBURSEMENT STUDY

The act requires PURA to study the feasibility of creating a PURA administered program to reimburse residential electric company customers for the loss of refrigerated food and medications caused by electricity outages lasting over 48 hours. In the program (1) reimbursements cannot exceed \$150 for food and \$200 for medications, (2) customer applications for reimbursement must be filed with electric companies within 30 days after service is restored, and (3) customers must submit an itemized list of their spoiled food or medications and proof of the losses.

Under the act, PURA must submit a report to the Energy and Technology Committee by February 1, 2013, on:

1. how it would establish a reimbursement program;
2. the program's application process;
3. each electric company's role in administering the program;
4. the program's funding mechanism and funding cap;
5. the documents needed to prove losses;

6. whether the program would be limited to customers within certain income levels; and
7. any necessary legislative changes.

DEEP TEMPORARY AUTHORIZATIONS

By law, the DEEP commissioner can issue a temporary authorization for certain activities that otherwise require general permits if (1) the activity will last for no more than 30 days and will not pose a significant threat to human health and the environment and (2) the authorization is needed to protect the public interest and does not conflict with relevant federal law. Prior law allowed an authorization to be renewed once and prohibited the commissioner from issuing temporary authorizations for the same activity more than once in 12 months.

The act expands the scope of activities for which the commissioner can issue these authorizations to include minor activities in wetlands and water courses and stream channel encroachment lines. It also (1) increases the amount of time allowed for the authorizations to 90 days, which do not have to be consecutive; (2) ends the commissioner's ability to renew an authorization; and (3) requires 12 calendar months to have passed before the commissioner can issue an authorization for the same activity.

Public Act 12-126 (House Bill 5233)

An Act Concerning Workers' Compensation for Firefighters

(Signed by the Governor 6/15/2012)

This act extends workers' compensation coverage for mental or emotional impairment to a firefighter diagnosed with post-traumatic stress disorder (PTSD) because the firefighter witnessed the death of another firefighter while engaged in the line of duty. To be eligible, the firefighter (1) must be diagnosed by a licensed and board certified mental health professional who determines the PTSD stems from witnessing the death of another firefighter and (2) is not subject to any other exclusion under workers' compensation law. It extends this coverage to volunteer or paid uniformed municipal firefighters.

The workers' compensation benefits under the act are limited to treatment from a practicing psychologist or psychiatrist on an approved list established by the Workers' Compensation Commission chairperson. This differs from full workers' compensation coverage in that it does not provide wage replacement benefits.

Previously, workers' compensation only covered a mental or emotional injury under two scenarios. In the first scenario, a mental or emotional injury is compensable under workers' compensation if it arises out of a physical injury that occurs on the job or is job-related. In these cases, the workers' compensation claim starts with the physical injury and the employee is eligible for wage replacement and medical benefits.

In the second, a police officer's mental and emotional injury that arises from a job-related incident in which the officer was subject to the attempted use of deadly force or the officer used

deadly force on another person is covered under worker's compensation, but the benefit is limited to treatment by an approved psychologist or psychiatrist.

EFFECTIVE DATE: Upon passage and applicable to any claim filed on or after that date.

Public Act 12-166 (House Bill 5038)

An Act Implementing the Governor's Budget Recommendations Concerning An All-Payer Database Program

(Signed by the Governor 6/15/2012)

Subject to the Office of Health Reform and Innovation's (OHRI) ability to secure federal funding and funds from private sources, this act creates an all-payer claims database program for receiving and storing data relating to medical and dental insurance claims, pharmacy claims, and other insurance claims information from enrollment and eligibility files. The act requires insurers and various other "reporting entities" that administer health care claims and payments to provide information for inclusion in the database.

The act allows the Office of Policy and Management (OPM) secretary, in consultation with OHRI, to adopt regulations to implement and administer the database program. The act establishes civil penalties of up to \$1,000 per day for entities that fail to report as required by those regulations.

The act makes information in the database broadly available for reviewing health care use, cost, and quality. Data disclosure must protect the confidentiality of individual health information (see BACKGROUND).

The act requires OHRI to oversee the planning, implementation, and administration of the program. It also allows the special advisor to the governor on health care reform (who directs OHRI's activities) to contract with an outside entity to plan, implement, or administer the program, but she must do so in consultation with an existing working group that is required by law to develop a plan for a statewide multipayer data initiative. The act names the working group the All-Payer Claims Database Advisory Group, expands its membership, and requires it to report on the database program.

The act requires the special advisor to seek federal or private funding to cover the costs of the database program, and prohibits her from incurring costs for the program if she does not secure such funding.

The act also makes technical changes.

EFFECTIVE DATE: Upon passage

ALL-PAYER CLAIMS DATABASE PROGRAM

Program Implementation, Administration, and Purpose

PA 11-58 established OHRI within the Office of the Lieutenant Governor. OHRI is charged with coordinating and implementing the state's responsibilities under state and federal health care

reform, among other things, and is under the direction of the special advisor to the governor on health care reform.

The act requires OHRI to oversee the planning, implementation, and administration of the all-payer claims database program, including collecting, assessing, and reporting health care information relating to safety, quality, cost-effectiveness, access, and efficiency for all levels of health care.

Under the act, OHRI must ensure that data from reporting entities is securely collected, compiled, and stored according to state and federal law. OHRI also must conduct audits of submitted data to verify its accuracy.

Under the act, OHRI can accept grants from the federal government or any source to carry out its statutory duties. Under existing law, OHRI can already identify federal grants and other nonstate funding sources to help implement the federal Patient Protection and Affordable Care Act (PPACA).

The act requires the special advisor to seek funding from the federal government and private sources to cover the costs of planning, implementing, and administering the database program. By June 15 each year, she must submit to the OPM secretary, for his approval, a proposed program budget for the following fiscal year. The act prohibits the special advisor from incurring costs or contracting for services associated with the program if she has not secured such federal or private funding.

Reporting Entities

The act requires reporting entities to report health care information for inclusion in the database, in the form and manner the special advisor and OPM secretary prescribe. Under the act, reporting entities are:

1. insurers licensed to conduct health insurance business in Connecticut,
2. health care centers (i. e. , HMOs),
3. insurers or health care centers that provide state residents with coverage under Medicare parts C or D,
4. third-party administrators,
5. pharmacy benefits managers,
6. hospital service corporations,
7. nonprofit medical service corporations,
8. fraternal benefit societies that transact health insurance business in Connecticut,
9. dental plan organizations,
10. preferred provider networks, and
11. any other individual or legal entity that administers health care claims and payments under a contract or agreement or is required by law to administer such claims and payments.

The act specifies that reporting entities do not include employee welfare benefit plans, as defined in the federal Employee Retirement Income Security Act of 1974, that are also trusts established pursuant to collective bargaining subject to the federal Labor Management Relations Act (i. e. , the Taft-Hartley Act).

Civil Penalties

The act subjects reporting entities to civil penalties of up to \$1,000 per day for failing to report in accordance with the specific reporting requirements prescribed in regulations under the act. The penalty does not apply before the regulations are established. The act prohibits reporting entities from passing such monetary penalties on for purposes of rate-setting or reimbursement by third-party payers.

Use and Availability of Data

The act requires the special advisor to use the database to provide the state's health care consumers with information about the cost and quality of health care services so that they may make economically sound and medically appropriate health care decisions. She also must make data in the database available to any state agency, insurer, employer, health care provider, health care consumer, researcher, or the Connecticut Health Insurance Exchange (a quasi-public agency created to satisfy requirements of the PPACA) to allow them to review the data relating to health care utilization, cost, or service quality.

Any such disclosure must protect the confidentiality of health information as defined in federal Health and Human Services (HHS) regulations (see BACKGROUND) and other information as required by state and federal law.

Fees for Accessing Data

The act allows the special advisor to charge a fee to those seeking access to the database.

Contracting Authority

The act allows the special advisor, in consultation with the All-Payer Claims Database Advisory Group (see below), to contract with another person or entity to plan, implement, or administer the program.

The act allows the special advisor to contract for or take other necessary actions to obtain fee-for-service data under the state medical assistance program (e. g. , HUSKY Health) or Medicare parts A and B. Under the act, she may also contract for the collection, management, or analysis of data received from reporting entities, but any such contract must expressly prohibit the disclosure of the data for other purposes.

The act specifies that this contracting authority is an exception to the existing requirement that OHRI consult with the Sustinet Health Care Cabinet before hiring consultants needed to carry out its duties.

ADVISORY GROUP

Existing law requires OHRI to convene a working group to develop a plan implementing a statewide multipayer data initiative to improve the state's use of health care data from multiple sources to increase efficiency, enhance outcomes, and improve the understanding of health care spending in the public and private sectors.

The act specifies that the special advisor must convene the working group, and renames it the All-Payer Claims Database Advisory Group. It adds to the group's membership the Department

of Mental Health and Addiction Services commissioner, the health care advocate, the state chief information officer, and a representative of the Connecticut State Medical Society. The act also allows the special advisor to appoint additional members. By law, the group also includes the OPM secretary; the comptroller; the commissioners of public health, social services, and insurance; representatives of health insurance companies; health insurance purchasers; hospitals; consumer advocates; and health care providers.

Prior law required OHRI to report on the working group's plan to the Appropriations, Insurance and Real Estate, and Public Health committees, but did not specify a reporting deadline. The act instead requires the advisory group, by December 1, 2012, to report on the database program to these same legislative committees and to the governor. The report must include recommendations on (1) the person or entity to implement and administer the database program, (2) a timeline to transfer authority for implementing or administering the program to such person or entity, and (3) program administration.

BACKGROUND

Related Federal Law

HIPAA. The Health Insurance Portability and Accountability Act's (HIPAA) “privacy rule” sets national standards to protect the privacy of health information. “Covered entities” such as health care providers, health plans (e. g. , health insurers, HMOs, Medicare, and Medicaid), and health care clearinghouses must follow HIPAA rules. The HIPAA privacy rule protects individually identifiable health information by defining and limiting the circumstances under which covered entities may use or disclose such information.

Definition of Health Information. Under HHS regulations, “health information” means any information, whether oral or recorded in any form or medium, that:

1. is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse and
2. relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual (45 C. F. R. § 160. 103).

Public Act 12-1, June 12, 2012 Special Session - Sections 218 to 220 (House Bill 6001) An Act Implementing Provisions of the State Budget for the Fiscal Year Beginning July 1, 2012.

(Signed by the Governor 6/15/2012)

Sections 218 & 219—Connecticut Health Insurance Exchange Board Members and Employees

The bill makes the Healthcare Advocate a voting member of the Connecticut Health Insurance Exchange board. She is currently an ex-officio nonvoting board member. The bill also:

1. increases, from six to seven, the number of board members that constitutes a quorum;

2. expands outside employment and affiliations restrictions applicable to exchange board members and staff;
3. lengthens the term of the House majority leader's health care economist board appointee from one year to two years;
4. allows exchange employees to enroll in the state employee health plan if the exchange pays the enrollment costs; and
5. makes technical changes.

Outside Employment and Affiliations Restrictions

The law subjects exchange board members and staff to certain restrictions relating to their employment and affiliations. The bill expands upon these.

Specifically, under current law, board appointees cannot be employed by, serve as a consultant to, be a board member of, be affiliated with, or represent an insurer, insurance producer or broker, health care provider, health care facility, or health or medical clinic. The bill extends this restriction to all board members and staff.

Under current law, board members and staff cannot be members, board members, or employees of a trade association of insurers, insurance producers or brokers, health care providers, health care facilities, or health or medical clinics. The bill prohibits them from also being consultants to such trade associations.

In addition to the restrictions described above, the law prohibits board members and staff from being health care providers unless they receive no compensation as providers and have no ownership interest in a professional health care practice. A staff member may also be a health care provider if the exchange's chief executive officer approves the hiring to fill an area of needed expertise.

Board members may engage in private employment or in a profession or business, subject to any federal or state laws, regulations, and rules regarding ethics and conflict of interest.

The law specifies that it does not constitute a conflict of interest for a trustee, director, partner, or officer of any person, firm, or corporation, or any individual having a financial interest in the person, firm, or corporation, to serve as a board member. But such a member must abstain from any deliberation, action, or vote relating to the person, firm, or corporation.

EFFECTIVE DATE: Upon passage

Section 220—Connecticut Health Insurance Exchange Advanced Funding

The bill permits the Connecticut Health Insurance Exchange's CEO to request from the OPM secretary a funding advance from the General Fund if the CEO determines that (1) the exchange's current expenses exceed the amount of available cash and (2) an advance of funds from federal grants awarded to the exchange is not available. The CEO's request must be in writing and cannot exceed \$ 5 million.

If the OPM secretary approves the request, OPM must notify the treasurer and comptroller of the amount approved. The comptroller must draw a warrant for disbursement for that amount. The

bill prohibits the OPM secretary from approving any funding advance (1) until all prior advances have been repaid, (2) if sufficient federal grant awards to repay an advance are unavailable, and (3) after December 31, 2014.

The bill requires the exchange to (1) process draw-downs of federal grant funds as soon as practicable and (2) repay the comptroller the amount advanced from the General Fund within seven business days after receiving the advance. The exchange and OPM must provide reports regarding any approved advances as the comptroller requires.

EFFECTIVE DATE: July 1, 2012

Public Act 12-1, June 12, 2012 Special Session - Sections 252 to 264 (House Bill 6001)
An Act Implementing Provisions of the State Budget for the Fiscal Year Beginning July 1, 2012.

(Signed by the Governor 6/15/2012)

Sections 252 to 264—Underground Storage Tank Petroleum Clean-Up Program

Board Elimination

The bill eliminates the Underground Storage Tank Petroleum Clean-Up Review Board and designates DEEP as its successor with the DEEP commissioner administering the underground storage tank petroleum clean-up program.

It specifies that:

1. any application received by, filed with, or submitted to the board is considered received by, filed with, or submitted to the commissioner on the date it was received by, filed with, or submitted to the board, and
2. any board approval, determination, or decision on an application is considered made by the commissioner.

The bill also makes many conforming, minor, and technical changes to the underground storage tank program statutes.

Program Applicants

The bill prohibits the DEEP commissioner from ordering payment or reimbursement to an applicant until he determines the applicant's status as a municipal or other applicant, or a small, mid-size, or large station applicant.

For purposes of the underground storage tank petroleum clean-up program, the bill defines an “applicant” as anyone who filed a request or application for payment or reimbursement from the program, including a supplemental application.

A “small station applicant” is an applicant who owned, operated, leased, used, or had an interest in five or less in- or out-of-state parcels of real property when the program received the applicant's first application, on which an underground storage tank system was or had been previously located. The bill defines “mid-size station applicant” as an applicant who owned,

operated, leased, used, or had an interest in six to 99 such parcels and a “large station applicant” as an applicant who owned operated, leased, used, or had an interest in at least 100 such parcels, when the program received their first application. The bill does not explicitly require at least one parcel to be located in Connecticut. Gas station and other commercial applicants are covered by these provisions but it is unclear whether the bill excludes residential parcels. A “municipal applicant” is an applicant that is a consolidated or unconsolidated town, city, or borough and an “other applicant” is any applicant that is not a municipal applicant or a small, mid-size, or large station applicant.

The DEEP commissioner must make one determination per applicant which applies to all applications submitted by an applicant, including those which payment or reimbursement was ordered but has not been made. The bill requires the determination to be based on an applicant's status when the commissioner received such applicant's first application.

The bill requires each applicant to submit to the commissioner (1) information about whether it is a municipal or other applicant, or a small, mid-size, or large station applicant on a form he prescribes and (2) any additional information he believes necessary to make the determination. When determining an applicant's status, the commissioner must (1) include all affiliates of the applicant and (2) consider an underground storage tank system owned, operated, leased, or used by an applicant on another person's property to be an interest in a parcel. An “affiliate” is a person that directly or indirectly through at least one intermediary owns or controls, is owned or controlled by, or is under common control with an applicant.

The bill requires assignees of approved applications to assume the applicant status of the assignor.

Payment or Reimbursement Application Deadline

Under the bill, anyone who would qualify as a large station applicant must submit applications for payment or reimbursement before October 1, 2012.

The bill prohibits anyone who would qualify as a mid-size station applicant from submitting an application for payment or reimbursement beginning October 1, 2013. They can submit an application to the program by September 30, 2013 for a release reported to the DEEP commissioner before October 1, 2012, but not for a release reported on or after that date.

Beginning October 1, 2014, anyone who would qualify as a municipal, small station, or other applicant, may not submit an application for payment or reimbursement from the program. The bill allows them to submit an application by September 30, 2014 for a release reported to the commissioner before October 1, 2013, but not for a release reported on or after that date.

Payment or Reimbursement from the Program

Funding Distribution to Applicant Groups. The bill requires any amount available to the underground storage tank petroleum clean-up program for making payments or reimbursements to be equally distributed to the four applicant groups, each receiving one-quarter of the funds. (PA 12-189 authorizes \$ 36 million in bonds for DEEP to provide payment or reimbursement under the program. It authorizes \$ 9 million in bonds for each of the next four fiscal years.)

It creates an order of priority for redistributing the remaining funds of any applicant group when such group has no (1) pending applications or (2) applications that payment or reimbursement was ordered by the DEEP commissioner but has not been made.

Under the bill, the remaining funds first go to paying or reimbursing municipal and other applicants. If funds remain after redistributing to municipal and other applicants, the funds go to small station applicants. Any funds remaining after redistribution to municipal, other, and small station applicants go to mid-size station applicants. And remaining funds after redistribution to the applicants in the above-described priority order go to large station applicants.

Procedure for Municipal, Small Station, and Other Applicants. The bill prioritizes payment or reimbursement to municipal, small station, and other applicants by the date that the DEEP commissioner has ordered payment or reimbursement, beginning from the earliest order date. It specifies that if payment or reimbursement was ordered on the same day, the earliest application received by the commissioner is given priority. The payment priority applies to all submitted applications, including those which had payment or reimbursement ordered by the commissioner but not yet made.

Under the bill, if there are insufficient funds to pay or reimburse these applicants, the priority order carries over to the next fiscal quarter and from year to year if necessary.

Procedure for Mid-Size and Large Station Applicants. The bill creates a “reverse auction” system to make payments or reimbursements to mid-size and large station applicants (see below). It applies to all submitted applications including those with payment or reimbursement ordered but not yet made.

It provides priority payment or reimbursement to the mid-size and large station applicants that agree to accept the greatest reduction in the amount ordered by the DEEP commissioner (the “reduced payment election”). If at least two applicants choose the same reduced payment election, priority is given to the application the commissioner ordered earliest. If he ordered payment or reimbursement on the same day, priority is given to the earliest received application.

Mid-size and large station applicants that do not make a reduced payment election are paid when (1) the fiscal year payment amount reaches one dollar (FY19 and FY28, respectively, see below) and (2) all mid-size and large station applicants that made a reduced payment election with unpaid or unreimbursed applications ordered by the DEEP commissioner have been paid or reimbursed. Amongst these applicants, priority is determined by the date the commissioner ordered payments or reimbursements, beginning with the earliest date.

The bill specifies that if there are insufficient funds to pay or reimburse mid-size and large station applicants, the priority carries over to the next fiscal quarter and from year to year, if needed. The order of priority can change if an applicant makes a subsequent reduced payment election.

Mid-Size Station Applicant Payments. The bill prohibits payments to mid-size station applicants over 35 cents on each dollar the DEEP commissioner orders to be paid or reimbursed in the

fiscal year beginning July 1, 2012. This per dollar amount increases each subsequent fiscal year by 10 cents on each dollar but not over one dollar. The bill specifies that no payment or reimbursement made by the commissioner can exceed the per dollar amount in effect for that fiscal year.

The bill allows a mid-size station applicant to receive an additional 10 cents on each dollar of the amount the commissioner would pay if the applicant agrees in writing not to submit any applications for payment or reimbursement on and after October 1, 2012. But it prohibits an applicant from receiving more than one dollar on each dollar ordered to be paid or reimbursed. The bill prohibits using the additional funds to determine an applicant's priority status for payment.

Large Station Applicant Payments. Beginning in the same fiscal year, payments to large station applicants are capped at 20 cents on each dollar the DEEP commissioner orders to be paid or reimbursed. This per dollar amount increases each subsequent fiscal year by five cents on each dollar but not over one dollar. The bill prohibits payment or reimbursement over the per dollar amount in effect for that fiscal year.

Reduced Payment Election. Under the bill's reverse auction system, annually between July 1 and August 1, mid-size and large station applicants must submit a payment election to the DEEP commissioner on a form he prescribes indicating what reduced payment election the applicant accepts, if any. The commissioner can add time periods to submit the payment election.

An applicant is exempt from providing a payment election as described above if it (1) submits an application for the first time or (2) intends to keep its current payment election. First-time applicants must submit a payment election with their application. An applicant agreeing to accept a lower payment election than in a previous submission may file a new payment election.

The bill requires an applicant's payment election to apply to all applications submitted by the applicant including those the commissioner has ordered payment or reimbursement but not made. A payment election is effective no matter when the commissioner orders payment or reimbursement or when it is made. The bill (1) specifies that a payment election is final and (2) prohibits an applicant from modifying an election unless agreeing to a lower reduced payment election.

Under the bill, accepting payment or reimbursement in the amount contained in a reduced payment election is final and full payment of all applications covered by the election. The bill specifies that by accepting payment or reimbursement on a reduced payment election, an applicant agrees it will not seek additional payment or reimbursement in an administrative or judicial proceeding for any cost, expense, or other obligation associated with the applications.

Financial Responsibility

The bill phases out the program as a financial assurance mechanism. By federal and state law, owners and operators of underground storage tanks must demonstrate the ability to pay for cleanup or third-party liability compensation (see BACKGROUND).

The bill prohibits, beginning October 1, 2012, anyone required to meet the financial responsibility requirements who owns or operates at least one underground storage tank system on more than five separate parcels from demonstrating such responsibility through the program.

It prohibits (1) municipalities and (2) owners or operators of at least one underground storage tank system on five or less separate parcels who must meet the financial responsibility requirements, from demonstrating responsibility through the program starting on October 1, 2013.

The bill requires an owner or operator, within 30 days of a written request from the DEEP commissioner, to provide him with any information he believes is necessary to determine the owner or operator's prohibition date. It requires all in- and out-of-state underground storage tank systems to be included in determining an owner's or operator's status.

Certification of Approval

Under current law, applicants seeking payment or reimbursement must show that the labor, equipment, and materials provided and the services and activities undertaken in response to a release or suspected release are approved in writing. If total costs, expenses, or other obligations are \$ 250,000 or less, the DEEP commissioner or a licensed environmental professional (LEP) can provide such approval. The DEEP commissioner must approve total costs, expenses, or other obligations above \$ 250,000, but he can allow an LEP to do so.

By law, an LEP must submit a specific certification for the approval, stating that the labor, equipment, materials, services, and activities were (1) appropriate to abate an emergency, or (2) performed under a plan to ensure that a release or suspected release is or was investigated and remediated.

The bill specifies that the certification must be executed. It also prohibits the DEEP commissioner from ordering or making payment or reimbursement from the program if an application that relies on LEP approval does not include such certification.

EFFECTIVE DATE: Upon passage

Background

Underground Storage Tank Petroleum Clean-Up Program. The underground storage tank petroleum clean-up program is a federally approved program that provides payment and reimbursement for environmental investigation and remediation costs incurred from leaking commercial tanks and certain related claims. It also enables owners and operators of federally regulated petroleum underground storage tanks to demonstrate financial responsibility through the program.

Financial Responsibility. Federal law requires certain underground storage tank owners and operators to demonstrate the ability to pay for cleanup or third-party liability compensation from a tank release (40 CFR § 280. 90 et seq.). It enables owners or operators to show financial responsibility through a state fund that provides some or all financial responsibility to the degree it pays for cleanup and third-party compensation. An owner or operator can also show demonstrate financial responsibility through such things as insurance coverage, a financial test of

self-issuance, a trust, or obtaining a corporate guarantee, surety bond, or letter of credit. State agencies are responsible for ensuring that owners and operators comply with the federal requirements. Connecticut's underground storage tank regulations also require owner and operator financial responsibility (Conn. Agencies Reg. § 22a-449(d)-109).

Public Act 12-119 - Sections 4 and 5 (Senate Bill 234)
An Act Concerning Certain Social Services Programs
(Signed by the Governor 6/15/2012)

Sections 4 & 5—Investigating Medicaid Participants for other Health Insurance

The law requires health insurers, including self-insured plans; group plans regulated by federal law; service benefit plans; managed care organizations; health care centers; and entities that perform administrative services for them, to provide the DSS commissioner or a designee information about a policy-holder's transactions when presented with an official, written request to do so. DSS prescribes the format for presenting the information and uses it to identify, determine, or establish Medicaid beneficiaries with other (third-party) insurance.

The act adds third-party administrators to those that must supply this information. These are organizations that process insurance claims or certain aspects of employee benefit plans for separate entities.

By law, the information DSS requires is (1) any coverage period for a person his or her spouse or dependent; (2) covered services; (3) the name and address (presumably of the insured); and (4) the plan's identifying number. The act adds date of birth, Social Security number, plan type, services covered, and policy effective and termination dates. The department may request this information of any legal entity described above. Responses are due 90 days after the department's initial request and at least monthly thereafter.

Automated Data Matches

Prior law required any of the entities described above to either conduct, or allow the DSS commissioner or his designee to conduct, automated data matches to identify recipients and parents of minor children with overlapping coverage. The commissioner reimbursed the insurer for its reasonable, documented costs when it performed this function for DSS. Under the act, only the department can perform this function.

DSS Recoveries or Claims for Indemnification

When an individual applies to DSS for assistance, he or she or a legally liable relative makes DSS automatically entitled to any right of recovery those individuals have from third parties, including those providing health care items or services. The act adds third-party administrators to the entities whose payments are passed through to DSS. It also specifies that DSS' right to recovery or indemnification is not affected by the insured's failure to comply with prior authorization rules (i.e., to get the insurer's permission before undergoing certain types of procedures). The law specifies other procedural errors that will not negate DSS' right to payment.

EFFECTIVE DATE: Upon passage

Public Act 12-142 (House Bill 5545)

An Act Concerning Financial Liability for Ambulance Services, Evidence of Collateral Source Payments and Evidence of Bills from Treating Healthcare Providers

(Signed by the Governor 6/15/2012)

This act generally provides that anyone who receives emergency medical treatment or transportation services from a licensed or certified ambulance service is liable for the reasonable and necessary cost of those services, even if the person did not agree or consent to the liability.

Under the act, this provision is subject to certain conditions in existing law, including the Department of Public Health (DPH) commissioner's rate setting for ambulance services and requirements that insurers cover medically necessary ambulance services. Also, the provision does not apply to anyone receiving services for injuries arising out of and in the course of his or her employment, as defined in the workers' compensation law (see BACKGROUND).

The act also makes changes to the law on determining economic damages in personal injury or wrongful death cases. It makes evidence that a specified health care provider accepted payment from a claimant that is less than the total amount billed, or evidence that an insurer paid less than that total amount, admissible for purposes of the collateral source rule (the requirement that courts reduce economic damage awards by the amount the claimant received from health insurance or other collateral sources). This provision applies to bills by state-licensed physicians, physician assistants, dentists, chiropractors, natureopaths, physical therapists, podiatrists, psychologists, optometrists, advanced practice registered nurses, and state-certified emergency medical technicians.

Under the act, in cases in which the law allows such health care providers' signed reports and bills for treatment to be introduced as business entry evidence without the provider testifying (see BACKGROUND), the total amount of the provider's bill is admissible evidence of the cost of reasonable and necessary medical care. The calculation of the total amount of the bill must not be reduced because (1) the provider accepts less than the total bill or (2) an insurer pays less than that amount.

Existing law provides that its provisions allowing certain business entry evidence to be introduced without such providers testifying do not preclude either party or the court from calling the treating provider as a witness. The act specifies that the purposes for which they may be called to testify include giving testimony on the reasonableness of their bills for treatment.

EFFECTIVE DATE: October 1, 2012, and the provisions on collateral sources and business entry evidence are applicable to actions pending on or filed on or after that date.

LIABILITY FOR AMBULANCE PAYMENTS

The act's provisions on liability for ambulance services are subject to the following provisions in existing law:

1. the general requirement that health insurance policies provide coverage for medically necessary ambulance services (CGS §§ 38a-498 and 38a-525) and
2. the DPH commissioner's duties regarding emergency medical services including, among other things, setting rates for ambulance services (CGS § 19a-177).

By law, insurers are not required to provide ambulance benefits in excess of the maximum rates set by DPH.

EVIDENCE OF COLLATERAL SOURCE PAYMENTS

In personal injury or wrongful death cases, the law generally requires courts to reduce economic damages by the amount paid to the claimant by collateral sources (e. g. , health insurance), less the amount paid, contributed, or forfeited by the claimant to secure the collateral source benefit. (Both the amount of collateral sources, and the amount paid to secure them, also include amounts paid on the claimant's behalf.)

After the jury or court finds liability and awards damages, and before the court enters judgment, the court must receive evidence on the total amount of collateral sources that have been paid for the claimant's benefit as of the date the court enters judgment. Under the act, evidence that a specified health care provider accepted an amount less than the provider's total bill, or evidence that an insurer paid less than the total bill, is admissible for this purpose.

By law, there is no reduction for (1) collateral sources for which a right of subrogation exists or (2) the amount of collateral sources equal to the reduction in the claimant's economic damages due to his or her percentage of negligence (CGS § 52-225a(a)).

BACKGROUND

Injuries Arising out of and in the Course of Employment

State workers' compensation law defines “arising out of and in the course of employment” as an accidental injury to, or an occupational disease of, an employee originating while the employee was engaged in the line of his or her duty in the business or affairs of the employer upon the employer's premises, or while engaged elsewhere upon the employer's business or affairs by the employer's express or implied direction. There are additional provisions related to specific employees (e. g. , police officers and firefighters) as well as other conditions and exceptions (e. g. , injuries due to alcohol or narcotic use) (CGS § 31-275).

Business Entry Evidence

The law allows signed reports and bills of the treating health care providers listed above to be introduced in any civil action as business entry evidence without calling the provider to testify. It is presumed that the signature on the report is that of the treating provider, and that the report and bill were made in the ordinary course of business. The use of such evidence must not give rise to an adverse inference concerning the provider's testimony or lack thereof.

In personal injury cases, the law also allows the records and reports of such providers, as well as certain other professionals, to be admitted into evidence if the provider or other professional has (1) died before trial or (2) is physically or mentally disabled and thus no longer practicing. For such evidence to be introduced, the court must determine that the person is disabled to such an extent that he or she cannot testify (CGS § 52-174).