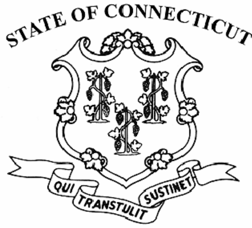

General Assembly **Substitute Bill No. 11**

January Session, 2011 *____SB00011INS___031011____*

AN ACT CONCERNING THE RATE APPROVAL PROCESS FOR CERTAIN HEALTH INSURANCE POLICIES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-481 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective July 1, 2011*):

3 (a) No individual health insurance policy shall be delivered or
4 issued for delivery to any person in this state, nor shall any
5 application, rider or endorsement be used in connection with such
6 policy, until a copy of the form thereof and of the classification of risks
7 and the premium rates have been filed with the commissioner. The
8 commissioner shall adopt regulations, in accordance with chapter 54,
9 to establish a procedure for reviewing such policies. The commissioner
10 shall disapprove the use of such form at any time if it does not comply
11 with the requirements of law, or if it contains a provision or provisions
12 **[**which**]** that are unfair or deceptive or **[**which**]** that encourage
13 misrepresentation of the policy. The commissioner shall notify, in
14 writing, the insurer **[**which**]** that has filed any such form of the
15 commissioner's disapproval, specifying the reasons for disapproval,
16 and ordering that no such insurer shall deliver or issue for delivery to
17 any person in this state a policy on or containing such form. The
18 provisions of section 38a-19 shall apply to such orders.

19 (b) (1) No rate filed under the provisions of subsection (a) of this

20 section shall be effective [until the expiration of thirty days after it has
21 been filed or] unless [sooner] approved by the commissioner. [in
22 accordance with regulations adopted pursuant to this subsection.] The
23 commissioner shall adopt regulations, in accordance with chapter 54,
24 to prescribe standards to ensure that such rates shall not be excessive,
25 inadequate or unfairly discriminatory, as described in section 6 of this
26 act. [The commissioner may disapprove such rate within thirty days
27 after it has been filed if it fails to comply with such standards, except
28 that no rate filed under the provisions of subsection (a) of this section
29 for any Medicare supplement policy shall be effective unless approved
30 in accordance with section 38a-474.]

31 (2) Any rate filed under the provisions of subsection (a) of this
32 section for health insurance that provides coverage of the type
33 specified in subdivisions (1), (2), (4), (7), (11) and (12) of section 38a-469
34 shall be approved in accordance with section 6 of this act.

35 (c) (1) No rate filed under the provisions of subsection (a) of this
36 section for any Medicare supplement policy shall be effective unless
37 approved in accordance with section 38a-474.

38 (2) No insurance company, fraternal benefit society, hospital service
39 corporation, medical service corporation, health care center or other
40 entity [which] that delivers or issues for delivery in this state any
41 Medicare supplement policies or certificates shall incorporate in its
42 rates or determinations to grant coverage for Medicare supplement
43 insurance policies or certificates any factors or values based on the age,
44 gender, previous claims history or the medical condition of any person
45 covered by such policy or certificate. [, except for plans "H" to "J",
46 inclusive, as provided in section 38a-495b. In plans "H" to "J", inclusive,
47 previous claims history and the medical condition of the applicant may
48 be used in determinations to grant coverage under Medicare
49 supplement policies and certificates issued prior to January 1, 2006.]

50 [(d) Rates on a particular policy form will not be deemed excessive
51 if the insurer has filed a loss ratio guarantee with the Insurance

52 Commissioner which meets the requirements of subsection (e) of this
53 section provided (1) the form of such loss ratio guarantee has been
54 explicitly approved by the Insurance Commissioner, and (2) the
55 current expected lifetime loss ratio is not more than five per cent less
56 than the filed lifetime loss ratio as certified by an actuary. The insurer
57 shall withdraw the policy form if the commissioner determines that
58 the lifetime loss ratio will not be met. Rates also will not be deemed
59 excessive if the insurer complies with the terms of the loss ratio
60 guarantee. The Insurance Commissioner may adopt regulations, in
61 accordance with chapter 54, to assure that the use of a loss ratio
62 guarantee does not constitute an unfair practice.

63 (e) Premium rates shall be deemed approved upon filing with the
64 Insurance Commissioner if the filing is accompanied by a loss ratio
65 guarantee. The loss ratio guarantee shall be in writing, signed by an
66 officer of the insurer, and shall contain as a minimum the following:

67 (1) A recitation of the anticipated lifetime and durational target loss
68 ratios contained in the original actuarial memorandum filed with the
69 policy form when it was originally approved;

70 (2) A guarantee that the actual Connecticut loss ratios for the
71 experience period in which the new rates take effect and for each
72 experience period thereafter until any new rates are filed will meet or
73 exceed the loss ratios referred to in subdivision (1) of this subsection. If
74 the annual earned premium volume in Connecticut under the
75 particular policy form is less than one million dollars and therefore not
76 actuarially credible, the loss ratio guarantee will be based on the actual
77 nation-wide loss ratio for the policy form. If the aggregate earned
78 premium for all states is less than one million dollars, the experience
79 period will be extended until the end of the calendar year in which one
80 million dollars of earned premium is attained;

81 (3) A guarantee that the actual Connecticut or nation-wide loss ratio
82 results, as the case may be, for the experience period at issue will be
83 independently audited by a certified public accountant or a member of

84 the American Academy of Actuaries at the insurer's expense. The audit
85 shall be done in the second quarter of the year following the end of the
86 experience period and the audited results must be reported to the
87 Insurance Commissioner not later than June thirtieth following the end
88 of the experience period;

89 (4) A guarantee that affected Connecticut policyholders will be
90 issued a proportional refund, which will be based on the premiums
91 earned, of the amount necessary to bring the actual loss ratio up to the
92 anticipated loss ratio referred to in subdivision (1) of this subsection. If
93 nation-wide loss ratios are used, the total amount refunded in
94 Connecticut shall equal the dollar amount necessary to achieve the loss
95 ratio standards multiplied by the total premium earned from all
96 Connecticut policyholders who will receive refunds and divided by
97 the total premium earned in all states on the policy form. The refund
98 shall be made to all Connecticut policyholders who are insured under
99 the applicable policy form as of the last day of the experience period
100 and whose refund would equal two dollars or more. The refund shall
101 include interest, at six per cent, from the end of the experience period
102 until the date of payment. Payment shall be made during the third
103 quarter of the year following the experience period for which a refund
104 is determined to be due;

105 (5) A guarantee that refunds less than two dollars will be
106 aggregated by the insurer. The insurer shall deposit such amount in a
107 separate interest-bearing account in which all such amounts shall be
108 deposited. At the end of each calendar year each such insurer shall
109 donate such amount to The University of Connecticut Health Center;

110 (6) A guarantee that the insurer, if directed by the Insurance
111 Commissioner, shall withdraw the policy form and cease the issuance
112 of new policies under the form in this state if the applicable loss ratio
113 exceeds the durational target loss ratio for the experience period by
114 more than twenty per cent, provided the calculations are based on at
115 least two thousand policyholder-years of experience either in
116 Connecticut or nation-wide.

117 (f) For the purposes of this section:

118 (1) "Loss ratio" means the ratio of incurred claims to earned
119 premiums by the number of years of policy duration for all combined
120 durations; and

121 (2) "Experience period" means the calendar year for which a loss
122 ratio guarantee is calculated.**]**

123 **[**(g)**]** <u>(d)</u> Nothing in this chapter shall preclude the issuance of an
124 individual health insurance policy **[**which**]** <u>that</u> includes an optional
125 life insurance rider, provided the optional life insurance rider **[**must**]**
126 <u>shall</u> be filed with and approved by the Insurance Commissioner
127 pursuant to section 38a-430. Any company offering such policies for
128 sale in this state shall be licensed to sell life insurance in this state
129 pursuant to the provisions of section 38a-41.

130 **[**(h)**]** <u>(e)</u> No insurance company, fraternal benefit society, hospital
131 service corporation, medical service corporation, health care center or
132 other entity that delivers, issues for delivery, amends, renews or
133 continues an individual health insurance policy in this state shall: (1)
134 Move an insured individual from a standard underwriting
135 classification to a substandard underwriting classification after the
136 policy is issued; (2) increase premium rates due to the claim experience
137 or health status of an individual who is insured under the policy,
138 except that the entity may increase premium rates for all individuals in
139 an underwriting classification due to the claim experience or health
140 status of the underwriting classification as a whole; or (3) use an
141 individual's history of taking a prescription drug for anxiety for six
142 months or less as a factor in its underwriting unless such history arises
143 directly from a medical diagnosis of an underlying condition.

144 Sec. 2. Section 38a-513 of the general statutes is repealed and the
145 following is substituted in lieu thereof (*Effective July 1, 2011*):

146 (a) No group health insurance policy, as defined by the
147 commissioner, or certificate shall be **[**issued or**]** delivered <u>or issued for</u>

148 delivery in this state unless a copy of the form for such policy or
149 certificate has been submitted to and approved by the commissioner
150 [under the regulations adopted pursuant to this section] and the
151 classification of risks and the premium rates have been filed with the
152 commissioner. The commissioner shall adopt regulations, in
153 accordance with chapter 54, concerning the provisions [,] and
154 submission [and approval] of such policies and certificates and
155 establishing a procedure for reviewing such policies and certificates. If
156 the commissioner issues an order disapproving the use of such form,
157 the provisions of section 38a-19 shall apply to such order.

158 (b) (1) No rate filed under the provisions of subsection (a) of this
159 section shall be effective unless approved by the commissioner. The
160 commissioner shall adopt regulations, in accordance with chapter 54,
161 to prescribe standards to ensure that such rates shall not be excessive,
162 inadequate or unfairly discriminatory, as described in section 6 of this
163 act.

164 (2) Any rate filed under the provisions of subsection (a) of this
165 section for health insurance that provides coverage of the type
166 specified in subdivisions (1), (2), (4), (7), (11) and (12) of section 38-469
167 shall be approved in accordance with section 6 of this act.

168 [(b)] (c) No insurance company, fraternal benefit society, hospital
169 service corporation, medical service corporation, health care center or
170 other entity which delivers or issues for delivery in this state any
171 Medicare supplement policies or certificates shall incorporate in its
172 rates or determinations to grant coverage for Medicare supplement
173 insurance policies or certificates any factors or values based on the age,
174 gender, previous claims history or the medical condition of any person
175 covered by such policy or certificate. [, except for plans "H" to "J",
176 inclusive, as provided in section 38a-495b. In plans "H" to "J", inclusive,
177 previous claims history and the medical condition of the applicant may
178 be used in determinations to grant coverage under Medicare
179 supplement policies and certificates issued prior to January 1, 2006.]

180 [(c)] <u>(d)</u> Nothing in this chapter shall preclude the issuance of a
181 group health insurance policy [which] <u>that</u> includes an optional life
182 insurance rider, provided the optional life insurance rider must be
183 filed with and approved by the Insurance Commissioner pursuant to
184 section 38a-430. Any company offering such policies for sale in this
185 state shall be licensed to sell life insurance in this state pursuant to the
186 provisions of section 38a-41.

187 [(d)] <u>(e)</u> Not later than January 1, 2009, the commissioner shall adopt
188 regulations, in accordance with chapter 54, to establish minimum
189 standards for benefits in group specified disease policies, certificates,
190 riders, endorsements and benefits.

191 Sec. 3. Subsection (a) of section 38a-183 of the general statutes is
192 repealed and the following is substituted in lieu thereof (*Effective July*
193 *1, 2011*):

194 (a) A health care center governed by sections 38a-175 to 38a-192,
195 inclusive, <u>as amended by this act,</u> shall not enter into any agreement
196 with subscribers unless and until it has filed with the commissioner a
197 full schedule of the amounts to be paid by the subscribers and has
198 obtained the commissioner's approval [thereof] <u>in accordance with</u>
199 <u>section 6 of this act</u>. The commissioner [may refuse such approval if he
200 finds such amounts to] <u>shall adopt regulations, in accordance with</u>
201 <u>chapter 54, to prescribe standards to ensure that such amounts shall</u>
202 <u>not</u> be excessive, inadequate or discriminatory<u>, as described in section</u>
203 <u>6 of this act</u>. Each such health care center shall not enter into any
204 agreement with subscribers unless and until it has filed with the
205 commissioner a copy of such agreement or agreements, including all
206 riders and endorsements thereon, and until the commissioner's
207 approval thereof has been obtained. The commissioner shall, within a
208 reasonable time after the filing of any request for an approval of [the
209 amounts to be paid,] any agreement or any form, notify the health care
210 center of [either his] <u>said commissioner's</u> approval or disapproval
211 thereof.

212 Sec. 4. Section 38a-208 of the general statutes is repealed and the
213 following is substituted in lieu thereof (*Effective July 1, 2011*):

214 No such corporation shall enter into any contract with subscribers
215 unless and until it has filed with the Insurance Commissioner a full
216 schedule of the rates to be paid by the subscribers and has obtained
217 said commissioner's approval **[**thereof**]** in accordance with section 6 of
218 this act. The commissioner **[**may refuse such approval if he finds such
219 rates to**]** shall adopt regulations, in accordance with chapter 54, to
220 prescribe standards to ensure that such amounts shall not be excessive,
221 inadequate or discriminatory, as described in section 6 of this act. No
222 hospital service corporation shall enter into any contract with
223 subscribers unless and until it has filed with the Insurance
224 Commissioner a copy of such contract, including all riders and
225 endorsements thereof, and until said commissioner's approval thereof
226 has been obtained. The Insurance Commissioner shall, within a
227 reasonable time after the filing of any such form, notify such
228 corporation **[**either of his**]** of said commissioner's approval or
229 disapproval thereof.

230 Sec. 5. Section 38a-218 of the general statutes is repealed and the
231 following is substituted in lieu thereof (*Effective July 1, 2011*):

232 No such medical service corporation shall enter into any contract
233 with subscribers unless and until it has filed with the Insurance
234 Commissioner a full schedule of the rates to be paid by the subscriber
235 and has obtained said commissioner's approval **[**thereof**]** in accordance
236 with section 6 of this act. The commissioner **[**may refuse such approval
237 if he finds such rates are**]** shall adopt regulations, in accordance with
238 chapter 54, to prescribe standards to ensure that such amounts shall
239 not be excessive, inadequate or discriminatory, as described in section
240 6 of this act. No such medical service corporation shall enter into any
241 contract with subscribers unless and until it has filed with the
242 Insurance Commissioner a copy of such contract, including all riders
243 and endorsements thereof, and until said commissioner's approval
244 thereof has been obtained. The Insurance Commissioner shall, within a

245 reasonable time after the filing of any such form, notify such
246 corporation **[**either of his**]** <u>of said commissioner's</u> approval or
247 disapproval thereof.

248 Sec. 6. (NEW) (*Effective July 1, 2011*) (a) (1) With respect to a health
249 insurance policy, agreement or contract that provides coverage of the
250 type specified in subdivisions (1), (2), (4), (7), (11) and (12) of section
251 38a-469 of the general statutes, any (A) rate filed for such policy
252 pursuant to section 38a-481 of the general statutes, as amended by this
253 act, (B) rate filed for such policy pursuant to section 38a-513 of the
254 general statutes, as amended by this act, (C) schedule of amounts filed
255 for such agreement pursuant to section 38a-183 of the general statutes,
256 as amended by this act, (D) schedule of rates filed for such contract
257 pursuant to section 38a-208 of the general statutes, as amended by this
258 act, or (E) schedule of rates filed for such contract pursuant to section
259 38a-218 of the general statutes, as amended by this act, on or after July
260 1, 2011, shall be filed not later than one hundred twenty calendar days
261 prior to the proposed effective date of such rates or amounts.

262 (2) Each filer making a rate or amount filing pursuant to this
263 subsection shall:

264 (A) On the date the filer submits such rate or amount filing to the
265 Insurance Commissioner, clearly and conspicuously disclose to its
266 insureds or subscribers, in writing and in such form as the
267 commissioner may prescribe: (i) The proposed general rate or amount
268 increase and the dollar amount by which an insured's or subscriber's
269 policy or agreement will increase, including any increase because of
270 the insured's or subscriber's age or change in age rating classification
271 and the percentage increase or decrease of the proposed rate or
272 amount from the current rate or amount; (ii) a statement that the
273 proposed rate or amount is subject to Insurance Department review
274 and approval; and (iii) information on the insured's right to submit
275 public comment as set forth in this section; and

276 (B) Include with its rate or amount filing an actuarial memorandum,

277 certified by a qualified actuary, as defined in section 38a-78 of the
278 general statutes, that to the best of such actuary's knowledge, (i) such
279 rate or amount filing is in compliance with law, and (ii) the rate or
280 amount filing is not excessive, as defined in this section.

281 (3) (A) Notwithstanding the provisions of section 38a-69a of the
282 general statutes, the Insurance Department shall post on its Internet
283 web site all documents, materials and other information provided to or
284 requested by the department in relation to a rate or amount filing
285 made pursuant to this subsection, including, but not limited to,
286 financial reports, financial statements, actuarial reports and actuarial
287 memoranda. The rate or amount filing and the documents, materials
288 and other information shall be posted not later than three business
289 days after the department receives such filing, and such posting shall
290 be updated to include any correspondence between the department
291 and the filer.

292 (B) The department shall provide for a written public comment
293 period of thirty calendar days following the posting of such filing. The
294 department shall include in such posting the date the public comment
295 period closes and instructions on how to submit comments to the
296 department.

297 (b) Except where a hearing is required under subsection (d) of this
298 section, the commissioner shall issue a written decision approving,
299 disapproving or modifying a rate or amount filing not later than forty-
300 five days after such filing was made. Such decision shall specify all
301 factors used to reach such decision and shall be posted on the Internet
302 web site of the Insurance Department not later than two business days
303 after the commissioner issues such decision.

304 (c) The commissioner shall not approve a rate or amount filing
305 made under this section if it is excessive, inadequate or unfairly
306 discriminatory. The commissioner shall conduct an actuarial review to
307 determine if the methodology and assumptions used to develop the
308 rate or amount filing are actuarially sound and in compliance with the

309 Actuarial Standards of Practice issued by the Actuarial Standards
310 Board.

311 (A) A rate or amount is excessive if it is unreasonably high for the
312 insurance provided in relation to the underlying risks and costs after
313 due consideration to (i) the experience of the filer, (ii) the past and
314 projected costs of the filer including amounts paid and to be paid for
315 commissions, (iii) any transfers of funds to the holding or parent
316 company, subsidiary or affiliate of the filer, (iv) the filer's rate of return
317 on assets or profitability, as compared to similar filers, (v) a reasonable
318 margin for profit and contingencies, (vi) any public comments received
319 on such filing, and (vii) other factors the commissioner deems relevant.

320 (B) A rate or amount is inadequate if it is unreasonably low for the
321 insurance provided in relation to the underlying risks and costs and
322 continued use of such rate or amount would endanger solvency of the
323 filer.

324 (C) A rate or amount is unfairly discriminatory if the premium
325 charged for any classification is not reasonably related to the
326 underlying risks and costs, such that different premiums result for
327 insureds with similar risks and costs.

328 (d) (1) If a rate, schedule of amounts or schedule of rates filed
329 pursuant to subdivision (1) of subsection (a) of this section is for more
330 than a ten per cent increase in such rate or amount, not later than five
331 business days after such rate or amount filing has been posted on the
332 Internet web site of the Insurance Department, the commissioner shall
333 set a hearing date on such rate or amount filing and post the date,
334 place and time of the hearing in a conspicuous place on the Internet
335 web site of the department.

336 (2) Such hearing shall be (A) held not later than ninety calendar
337 days prior to the proposed effective date of such rate or amount, at a
338 place and time that is convenient to the public, and (B) conducted in
339 accordance with chapter 54 of the general statutes, this section and
340 section 7 of this act.

341 (3) Upon setting the date, place and time of the hearing on the
342 proposed rate or amount, the commissioner shall immediately notify
343 the filer of the date, place and time of the hearing.

344 (4) Not later than thirty calendar days after the hearing, the
345 commissioner shall issue a written decision approving, disapproving
346 or modifying the rate or amount filing. Such decision shall specify all
347 factors used to reach such decision and shall be posted on the Internet
348 web site of the Insurance Department not later than two business days
349 after the commissioner issues such decision.

350 (e) (1) If the Insurance Commissioner issues a decision to approve or
351 modify a rate or amount filing made pursuant to subsection (a) of this
352 section, the filer shall provide written notice to each insured or
353 subscriber by first class mail that states (A) the approved rate or
354 amount for the insured's or subscriber's policy or agreement, (B) any
355 increase in the rate or amount due to the insured's or subscriber's age
356 or change in age rating classification, and (C) the percentage increase
357 or decrease of the approved rate from the current rate of the insured or
358 subscriber.

359 (2) No such rate or amount shall be effective until thirty calendar
360 days after the notice has been sent by the filer as set forth in
361 subdivision (1) of this subsection.

362 (f) Each insurance company, health care center, hospital service
363 corporation or medical service corporation subject to the provisions of
364 this section shall disclose in writing to a prospective customer of a
365 policy or agreement that may be affected by a rate or amount filing
366 made pursuant to this section, (1) that the rate or amount of such
367 policy or agreement is under review by the Insurance Department, and
368 (2) the proposed increase or decrease in the rate or amount of such
369 policy or agreement.

370 (g) Each insurance company, health care center, hospital service
371 corporation or medical service corporation subject to the provisions of
372 this section shall retain records of all earned premiums and incurred

373 benefits per calendar year for each policy or agreement for which a
374 rate or amount filing is made pursuant to this section. Such records
375 shall be retained for not less than seven years after the date each such
376 filing is made and shall include records for any rider or endorsement
377 used in connection with such policy or agreement.

378 Sec. 7. (NEW) (*Effective July 1, 2011*) (a) Notwithstanding the
379 provisions of sections 4-176 and 4-177a of the general statutes, the
380 Healthcare Advocate or the Attorney General, or both, may be parties
381 to any hearing held pursuant to section 6 of this act.

382 (b) Subject to the provisions of section 4-181 of the general statutes,
383 (1) the Healthcare Advocate or the Attorney General, or both, shall
384 have access to the records of the Insurance Department regarding a
385 rate or amount filing made pursuant to section 6 of this act, and (2)
386 attorneys, actuaries, accountants and other experts who are part of the
387 Insurance Commissioner's staff and who review or assist in the
388 determination of such filing shall cooperate with the Healthcare
389 Advocate or Attorney General, or both, to carry out the provisions of
390 this section.

391 (c) The Healthcare Advocate or the Attorney General, or both, may
392 (1) summon and examine under oath, such witnesses as the Healthcare
393 Advocate or the Attorney General deems necessary to the review of a
394 rate or amount filing made pursuant to section 6 of this act, and (2)
395 require the filer or any holding or parent company or subsidiary of
396 such filer to produce books, vouchers, memoranda, papers, letters,
397 contracts and other documents, regardless of the format in which such
398 materials are stored. Such books, vouchers, memoranda, papers,
399 letters, contracts and other documents shall be limited to such
400 information or transactions between the filer and the holding or parent
401 company or subsidiary that are reasonably related to the subject matter
402 of the filing.

403 Sec. 8. Section 11-8a of the general statutes is repealed and the
404 following is substituted in lieu thereof (*Effective July 1, 2011*):

405 (a) The State Librarian shall, in the performance of his duties
406 pursuant to section 11-8, consult with the Attorney General, the
407 Probate Court Administrator and the chief executive officers of the
408 Connecticut Town Clerks Association and the Municipal Finance
409 Officers Association of Connecticut, or their duly appointed
410 representatives.

411 (b) The State Librarian may require each such state agency, or each
412 political subdivision of the state, including each probate district, to
413 inventory all books, records, papers and documents under its
414 jurisdiction and to submit to him for approval retention schedules for
415 all such books, records, papers and documents, or he may undertake
416 such inventories and establish such retention schedules, based on the
417 administrative need of retaining such books, records, papers and
418 documents within agency offices or in suitable records centers. Each
419 agency head, and each local official concerned, shall notify the State
420 Librarian of any changes in the administrative requirements for the
421 retention of any book, record, paper or document subsequent to the
422 approval of retention schedules by the State Librarian.

423 (c) If the Public Records Administrator and the State Archivist
424 determine that certain books, records, papers and documents which
425 have no further administrative, fiscal or legal usefulness are of
426 historical value to the state, the State Librarian shall direct that they be
427 transferred to the State Library. If the State Librarian determines that
428 such books, records, papers and documents are of no administrative,
429 fiscal, or legal value, and the Public Records Administrator and State
430 Archivist determine that they are of no historical value to the state, the
431 State Librarian shall approve their disposal, whereupon the head of the
432 state agency or political subdivision shall dispose of them as directed
433 by the State Librarian.

434 (d) The State Librarian may establish and carry out a program of
435 inventorying, repairing and microcopying for the security of those
436 records of political subdivisions of the state which he determines to
437 have permanent value; and he may provide safe storage for the

438 security of such microcopies of such records.

439 (e) The State Library Board may transfer any of the books, records,
440 documents, papers, files and reports turned over to the State Librarian
441 pursuant to the provisions of this section and section 11-4c. The State
442 Library Board shall have sole authority to authorize any such transfers.
443 The State Library Board shall adopt regulations pursuant to chapter 54
444 to carry out the provisions of this subsection.

445 (f) Each state agency shall cooperate with the State Librarian to
446 carry out the provisions of this section and shall designate an agency
447 employee to serve as the records management liaison officer for this
448 purpose.

449 (g) Notwithstanding the provisions of subsections (b) and (c) of this
450 section, the Insurance Department shall retain all records of any rate or
451 amount filing made pursuant to section 6 of this act for not less than
452 seven years after such filing was approved, disapproved or modified.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2011*	38a-481
Sec. 2	*July 1, 2011*	38a-513
Sec. 3	*July 1, 2011*	38a-183(a)
Sec. 4	*July 1, 2011*	38a-208
Sec. 5	*July 1, 2011*	38a-218
Sec. 6	*July 1, 2011*	New section
Sec. 7	*July 1, 2011*	New section
Sec. 8	*July 1, 2011*	11-8a

INS *Joint Favorable Subst.*