



General Assembly

January Session, 2015

**Raised Bill No. 6678**

LCO No. 3058



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:  
(INS)

**AN ACT CONCERNING THE LEGISLATIVE COMMISSIONERS'  
RECOMMENDATIONS FOR TECHNICAL AND OTHER CHANGES TO  
THE INSURANCE AND RELATED STATUTES.**

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

1 Section 1. Subsection (b) of section 38a-470 of the general statutes is  
2 repealed and the following is substituted in lieu thereof (*Effective*  
3 *October 1, 2015*):

4 (b) Any insurer, hospital [or] service corporation, medical service  
5 corporation, health care center or employee welfare benefit plan  
6 [which] that furnished benefits or services under a health insurance  
7 policy or a self-insured employee welfare benefit plan to any person  
8 suffering an injury or illness covered by the Workers' Compensation  
9 Act has a lien on the proceeds of any award or approval of any  
10 compromise made by a workers' compensation commissioner less  
11 attorneys' fees approved by the district commissioner and reasonable  
12 costs related to the proceeding, to the extent of benefits paid or services  
13 provided for the effects of the injury or illness arising out of and in the  
14 course of employment as a result of a controverted claim, provided

15 such plan, policy or contract provides for reduction, exclusion, or  
16 coordination of benefits of the policy or plan on account of workers'  
17 compensation benefits.

18 Sec. 2. Subsection (e) of section 38a-470 of the general statutes is  
19 repealed and the following is substituted in lieu thereof (*Effective*  
20 *October 1, 2015*):

21 (e) The insurance company providing workers' compensation  
22 coverage or the employer, if self-insured, shall reimburse the insurance  
23 company, hospital [or] service corporation, medical service  
24 corporation, health care center or employee welfare benefit plan  
25 providing benefits or service directly, to the extent of any such lien.  
26 The receipt of such reimbursement by such insurer, hospital [or]  
27 service corporation, medical service corporation, health care center or  
28 employee welfare benefit plan shall fully discharge such lien.

29 Sec. 3. Subdivision (5) of section 38a-478 of the general statutes is  
30 repealed and the following is substituted in lieu thereof (*Effective*  
31 *October 1, 2015*):

32 (5) "Managed care organization" means an insurer, health care  
33 center, hospital [or] service corporation, medical service corporation or  
34 other organization delivering, issuing for delivery, renewing,  
35 amending or continuing any individual or group health managed care  
36 plan in this state.

37 Sec. 4. Section 38a-489 of the general statutes is repealed and the  
38 following is substituted in lieu thereof (*Effective October 1, 2015*):

39 (a) Each individual health insurance policy providing coverage of  
40 the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of  
41 section 38a-469, delivered, issued for delivery, renewed, amended or  
42 continued in this state more than one hundred twenty days after July  
43 1, 1971, that provides that coverage of a dependent child shall  
44 terminate upon attainment of the limiting age for dependent children

45 specified in the policy shall also provide in substance that attainment  
46 of the limiting age shall not operate to terminate the coverage of the  
47 child if at such date the child is and continues thereafter to be both (1)  
48 incapable of self-sustaining employment by reason of mental or  
49 physical handicap, as certified by the child's physician on a form  
50 provided by the insurer, hospital [or] service corporation, medical  
51 service corporation or health care center, and (2) chiefly dependent  
52 upon the policyholder or subscriber for support and maintenance.

53 (b) Proof of the incapacity and dependency shall be furnished to the  
54 insurer, hospital [or] service corporation, medical service [plan]  
55 corporation or health care center by the policyholder or subscriber  
56 within thirty-one days of the child's attainment of the limiting age. The  
57 insurer, corporation or health care center may at any time require  
58 proof of the child's continuing incapacity and dependency. After a  
59 period of two years has elapsed following the child's attainment of the  
60 limiting age the insurer, corporation or health care center may require  
61 periodic proof of the child's continuing incapacity and dependency but  
62 in no case more frequently than once every year.

63 Sec. 5. Subdivision (5) of subsection (a) of section 38a-495a of the  
64 general statutes is repealed and the following is substituted in lieu  
65 thereof (*Effective October 1, 2015*):

66 (5) "Issuer" means any insurance company, fraternal benefit society,  
67 hospital [or] service corporation, medical service corporation, health  
68 care center or any other entity [which] that delivers or issues for  
69 delivery, in this state, any Medicare supplement policies or certificates.

70 Sec. 6. Subdivision (3) of subsection (b) of section 38a-498 of the  
71 general statutes is repealed and the following is substituted in lieu  
72 thereof (*Effective October 1, 2015*):

73 (3) This subsection shall not apply to any transaction between an  
74 ambulance provider and an insurance company, hospital [or] service  
75 corporation, medical service corporation, health care center or other

76 entity if the parties have entered into a contract providing for direct  
77 payment.

78 Sec. 7. Subsection (b) of section 38a-503e of the general statutes is  
79 repealed and the following is substituted in lieu thereof (*Effective*  
80 *October 1, 2015*):

81 (b) (1) Notwithstanding any other provision of this section, any  
82 insurance company, hospital [or] service corporation, medical service  
83 corporation, or health care center may issue to a religious employer an  
84 individual health insurance policy that excludes coverage for  
85 prescription contraceptive methods [which] that are contrary to the  
86 religious employer's bona fide religious tenets.

87 (2) Notwithstanding any other provision of this section, upon the  
88 written request of an individual who states in writing that prescription  
89 contraceptive methods are contrary to such individual's religious or  
90 moral beliefs, any insurance company, hospital [or] service  
91 corporation, medical service corporation [,] or health care center may  
92 issue to the individual an individual health insurance policy that  
93 excludes coverage for prescription contraceptive methods.

94 Sec. 8. Subsection (e) of section 38a-503e of the general statutes is  
95 repealed and the following is substituted in lieu thereof (*Effective*  
96 *October 1, 2015*):

97 (e) Notwithstanding any other provision of this section, any  
98 insurance company, hospital [or] service corporation, medical service  
99 corporation [,] or health care center [which] that is owned, operated or  
100 substantially controlled by a religious organization [which] that has  
101 religious or moral tenets [which] that conflict with the requirements of  
102 this section may provide for the coverage of prescription contraceptive  
103 methods as required under this section through another such entity  
104 offering a limited benefit plan. The cost, terms and availability of such  
105 coverage shall not differ from the cost, terms and availability of other  
106 prescription coverage offered to the insured.

107 Sec. 9. Section 38a-506 of the general statutes is repealed and the  
108 following is substituted in lieu thereof (*Effective October 1, 2015*):

109 Any insurer, hospital [or] service corporation, medical service  
110 corporation, health care center or fraternal benefit society, or any  
111 officer or agent thereof, delivering or issuing for delivery to any person  
112 in this state any policy in violation of any of the provisions of sections  
113 38a-481 to 38a-488, inclusive, as amended by this act, shall be fined not  
114 more than ten thousand dollars for each offense, and the commissioner  
115 may revoke the license of any foreign or alien insurer, or any agent  
116 thereof, violating any of said provisions.

117 Sec. 10. Subsections (c) and (d) of section 38a-508 of the general  
118 statutes are repealed and the following is substituted in lieu thereof  
119 (*Effective October 1, 2015*):

120 (c) If payment of a specific premium or subscription fee is required  
121 to provide coverage for a child legally placed for adoption with the  
122 insured or subscriber who is an adoptive parent or a prospective  
123 adoptive parent, the policy or contract may require that notification of  
124 acceptance of such child and payment of the required premium or fees  
125 be furnished to the insurer, hospital [or] service corporation, medical  
126 service corporation or health care center within thirty-one days after  
127 the acceptance of such child in order to continue coverage beyond such  
128 thirty-one-day period, provided failure to furnish such notice or pay  
129 such premium or fees shall not prejudice any claim originating within  
130 such thirty-one-day period.

131 (d) Such policy (1) shall cover such child legally placed for adoption  
132 on the same basis as other dependents, and (2) may not contain any  
133 provision concerning preexisting conditions, insurability, eligibility or  
134 health underwriting approval for a child legally placed for adoption,  
135 except that an insurer, hospital [or] service corporation, medical  
136 service corporation or health care center may require health  
137 underwriting for a child legally placed for adoption if a required

138 premium or subscription fee and completed application materials are  
139 not provided to the insurer, hospital [or] service corporation, medical  
140 service corporation or health care center before the expiration of the  
141 thirty-one-day period following the date the child was legally placed  
142 for adoption.

143 Sec. 11. Subsection (c) of section 38a-509 of the general statutes is  
144 repealed and the following is substituted in lieu thereof (*Effective*  
145 *October 1, 2015*):

146 (c) (1) Any insurance company, hospital [or] service corporation,  
147 medical service corporation [,] or health care center may issue to a  
148 religious employer an individual health insurance policy that excludes  
149 coverage for methods of diagnosis and treatment of infertility that are  
150 contrary to the religious employer's bona fide religious tenets.

151 (2) Upon the written request of an individual who states in writing  
152 that methods of diagnosis and treatment of infertility are contrary to  
153 such individual's religious or moral beliefs, any insurance company,  
154 hospital [or] service corporation, medical service corporation [,] or  
155 health care center may issue to or on behalf of the individual a policy  
156 or rider thereto that excludes coverage for such methods.

157 Sec. 12. Subsection (a) of section 38a-513e of the general statutes is  
158 repealed and the following is substituted in lieu thereof (*Effective*  
159 *October 1, 2015*):

160 (a) In the event (1) an employer, as defined in section 31-58,  
161 terminates an employee for any reason other than layoff or relocation  
162 or closing of a covered establishment, as defined in section 31-51n, or  
163 (2) an employee voluntarily terminates employment with an employer,  
164 such employer may elect not to pay the premium for such employee  
165 and any such employee's dependents under a group health insurance  
166 policy after the date of such employee's termination. In the event such  
167 employer makes such election, any insurer, health care center, hospital  
168 [or] service corporation, medical service corporation or fraternal

169 benefit society that issues such group health insurance policy shall  
170 credit such employer the amount of any premium paid by such  
171 employer with respect to such policy for such employee and such  
172 employee's dependents attributable to the period after the date of such  
173 employee's termination, provided the employer notifies the insurer,  
174 health care center, hospital [or] service corporation, medical service  
175 corporation or fraternal benefit society that issued such policy and the  
176 terminated employee not later than seventy-two hours after the  
177 termination. Upon the issuance or renewal of such policy, such insurer,  
178 health care center, hospital [or] service corporation, medical service  
179 corporation or fraternal benefit society shall provide such employer  
180 with relevant information related to such employer's election,  
181 including a notice that it is the employer's responsibility to remit to the  
182 terminated employee such employee's portion of the credited  
183 premium. Any such credit shall be applied to the employer's next  
184 month's premium. In the event of nonrenewal of such policy, the  
185 insurer, health care center, hospital [or] service corporation, medical  
186 service corporation or fraternal benefit society shall refund such credit  
187 to the employer.

188 Sec. 13. Section 38a-515 of the general statutes is repealed and the  
189 following is substituted in lieu thereof (*Effective October 1, 2015*):

190 (a) Each group health insurance policy providing coverage of the  
191 type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section  
192 38a-469 delivered, issued for delivery, renewed, amended or continued  
193 in this state more than one hundred twenty days after July 1, 1971, that  
194 provides that coverage of a dependent child of an employee or other  
195 member of the covered group shall terminate upon attainment of the  
196 limiting age for dependent children specified in the policy shall also  
197 provide in substance that attainment of the limiting age shall not  
198 operate to terminate the coverage of the child if at such date the child  
199 is and continues thereafter to be both (1) incapable of self-sustaining  
200 employment by reason of mental or physical handicap, as certified by  
201 the child's physician on a form provided by the insurer, hospital [or]

202 service corporation, medical service corporation [,] or health care  
203 center, and (2) chiefly dependent upon such employee or member for  
204 support and maintenance.

205 (b) Proof of the incapacity and dependency shall be furnished to the  
206 insurer, hospital [or] service corporation, medical service [plan]  
207 corporation or health care center by the employee or member within  
208 thirty-one days of the child's attainment of the limiting age. The  
209 insurer, corporation or center may at any time require proof of the  
210 child's continuing incapacity and dependency. After a period of two  
211 years has elapsed following the child's attainment of the limiting age  
212 the insurer, corporation or center may require periodic proof of the  
213 child's continuing incapacity and dependency but in no case more  
214 frequently than once every year.

215 Sec. 14. Subsection (b) of section 38a-523 of the general statutes is  
216 repealed and the following is substituted in lieu thereof (*Effective*  
217 *October 1, 2015*):

218 (b) Any insurance company, hospital [or] service corporation,  
219 medical service corporation or health care center authorized to do the  
220 business of health insurance in this state shall offer to any individual,  
221 partnership, corporation or unincorporated association providing  
222 group health insurance coverage of the type specified in subdivisions  
223 (1), (2), (4), (6), (11) and (12) of section 38a-469 for its employees or  
224 members, a group hospital or medical service plan or contract  
225 providing coverage for expenses incurred for comprehensive  
226 rehabilitation services under such terms and conditions as are agreed  
227 to by the policyholder and the insurer.

228 Sec. 15. Subdivision (3) of subsection (b) of section 38a-525 of the  
229 general statutes is repealed and the following is substituted in lieu  
230 thereof (*Effective October 1, 2015*):

231 (3) This subsection shall not apply to any transaction between an  
232 ambulance provider and an insurance company, hospital [or] service

233 corporation, medical service corporation, health care center or other  
234 entity if the parties have entered into a contract providing for direct  
235 payment.

236 Sec. 16. Subsection (b) of section 38a-530e of the general statutes is  
237 repealed and the following is substituted in lieu thereof (*Effective*  
238 *October 1, 2015*):

239 (b) (1) Notwithstanding any other provision of this section, any  
240 insurance company, hospital [or] service corporation, medical service  
241 corporation [,] or health care center may issue to a religious employer a  
242 group health insurance policy that excludes coverage for prescription  
243 contraceptive methods [which] that are contrary to the religious  
244 employer's bona fide religious tenets.

245 (2) Notwithstanding any other provision of this section, upon the  
246 written request of an individual who states in writing that prescription  
247 contraceptive methods are contrary to such individual's religious or  
248 moral beliefs, any insurance company, hospital [or] service  
249 corporation, medical service corporation [,] or health care center may  
250 issue to or on behalf of the individual a policy or rider thereto that  
251 excludes coverage for prescription contraceptive methods.

252 Sec. 17. Subsection (e) of section 38a-530e of the general statutes is  
253 repealed and the following is substituted in lieu thereof (*Effective*  
254 *October 1, 2015*):

255 (e) Notwithstanding any other provision of this section, any  
256 insurance company, hospital [or] service corporation, medical service  
257 corporation [,] or health care center [which] that is owned, operated or  
258 substantially controlled by a religious organization [which] that has  
259 religious or moral tenets [which] that conflict with the requirements of  
260 this section may provide for the coverage of prescription contraceptive  
261 methods as required under this section through another such entity  
262 offering a limited benefit plan. The cost, terms and availability of such  
263 coverage shall not differ from the cost, terms and availability of other

264 prescription coverage offered to the insured.

265 Sec. 18. Subsection (c) of section 38a-536 of the general statutes is  
266 repealed and the following is substituted in lieu thereof (*Effective*  
267 *October 1, 2015*):

268 (c) (1) Any insurance company, hospital [or] service corporation,  
269 medical service corporation [,] or health care center may issue to a  
270 religious employer a group health insurance policy that excludes  
271 coverage for methods of diagnosis and treatment of infertility that are  
272 contrary to the religious employer's bona fide religious tenets.

273 (2) Upon the written request of an individual who states in writing  
274 that methods of diagnosis and treatment of infertility are contrary to  
275 such individual's religious or moral beliefs, any insurance company,  
276 hospital [or] service corporation, medical service corporation [,] or  
277 health care center may issue to or on behalf of the individual a policy  
278 or rider thereto that excludes coverage for such methods.

279 Sec. 19. Section 38a-537 of the general statutes is repealed and the  
280 following is substituted in lieu thereof (*Effective October 1, 2015*):

281 (a) Any individual, partnership, corporation [,] or unincorporated  
282 association providing group health insurance coverage for its  
283 employees shall furnish each insured employee, upon cancellation or  
284 discontinuation of such health insurance, notice of the cancellation or  
285 discontinuation of such insurance. The notice shall be mailed or  
286 delivered to the insured employee not less than fifteen days next  
287 preceding the effective date of cancellation or discontinuation. Any  
288 individual or any such entity that fails to provide timely notice shall be  
289 fined not more than two thousand dollars for each violation. The Labor  
290 Commissioner shall have the authority to assess all such fines. This  
291 section shall apply to any such individual, partnership, corporation or  
292 unincorporated association that substitutes one policy providing  
293 group health insurance coverage for another such policy with no  
294 interruption in coverage.

295 (b) If any individual or any such entity fails to furnish notice  
296 pursuant to subsection (a) of this section, the individual or entity shall  
297 be liable for benefits to the same extent as the insurer, hospital [or]  
298 service corporation, medical service corporation or health care center  
299 would have been liable if coverage had not been cancelled or  
300 discontinued.

301 (c) Any individual, partnership, corporation [,] or unincorporated  
302 association [which] that makes deductions from an employee's wages  
303 for group health insurance coverage and fails to procure such coverage  
304 shall be liable for benefits to the same extent as the insurer, hospital  
305 [or] service corporation, medical service corporation or health care  
306 center would have been liable if coverage had been procured. If any  
307 corporation makes deductions from an employee's wages for group  
308 health insurance coverage and fails to procure such coverage, any  
309 officer of the corporation responsible for procuring such coverage for  
310 employees who wilfully failed to procure such coverage shall be  
311 personally liable for benefits to the same extent as the insurer, hospital  
312 [or] service corporation, medical service corporation or health care  
313 center would have been liable if coverage had been procured,  
314 provided [that] personal liability shall only be imposed against the  
315 officer in the event that an amount owed an employee due to the  
316 officer's failure cannot otherwise be collected from the corporation  
317 itself.

318 (d) Whenever an employer ceases doing business, any terminated  
319 employee whose group health insurance was discontinued on or  
320 before the date of termination of employment and who did not receive  
321 notice of such discontinuation pursuant to subsection (a) of this section  
322 shall be eligible for ninety days from the date of discontinuation to  
323 purchase as a conversion privilege an individual comprehensive health  
324 care plan for [himself] such employee and any dependents of such  
325 employee covered by the discontinued group health insurance plan  
326 from the former insurer, hospital [or] service corporation, medical  
327 service corporation, health care center or the Health Reinsurance

328 Association, if any insurer is not issuing such coverage, with coverage  
329 retroactive to the date of discontinuation. The employee shall pay the  
330 premiums for the period of retroactive coverage. No retroactive  
331 coverage may be purchased for a period during which the employee is  
332 eligible for benefits under another group plan.

333 Sec. 20. Section 38a-548 of the general statutes is repealed and the  
334 following is substituted in lieu thereof (*Effective October 1, 2015*):

335 Any insurer, hospital [or] service corporation, medical service  
336 corporation, health care center or fraternal benefit society, or any  
337 officer or agent thereof, delivering or issuing for delivery to any person  
338 in this state any policy in violation of any of the provisions of sections  
339 38a-512 to 38a-533, inclusive, as amended by this act, 38a-537 to 38a-  
340 542, inclusive, as amended by this act, and 38a-545, shall be fined not  
341 more than one thousand dollars for each offense, and the  
342 commissioner may revoke the license of any foreign or alien insurer, or  
343 any agent thereof, violating any of those provisions.

344 Sec. 21. Subsections (c) and (d) of section 38a-549 of the general  
345 statutes are repealed and the following is substituted in lieu thereof  
346 (*Effective October 1, 2015*):

347 (c) If payment of a specific premium or subscription fee is required  
348 to provide coverage for a child legally placed for adoption with the  
349 insured or subscriber who is an adoptive parent or a prospective  
350 adoptive parent, the policy may require that notification of acceptance  
351 of such child and payment of the required premium or fees be  
352 furnished to the insurer, hospital [or] service corporation, medical  
353 service corporation or health care center within thirty-one days after  
354 the acceptance of such child in order to continue coverage beyond such  
355 thirty-one-day period, provided failure to furnish such notice or pay  
356 such premium or fees shall not prejudice any claim originating within  
357 such thirty-one-day period.

358 (d) Such policy (1) shall cover such child legally placed for adoption

359 on the same basis as other dependents, and (2) may not contain any  
360 provision concerning preexisting conditions, insurability, eligibility or  
361 health underwriting approval for a child legally placed for adoption,  
362 except that an insurer, hospital [or] service corporation, medical  
363 service corporation or health care center may require health  
364 underwriting for a child legally placed for adoption if a required  
365 premium or subscription fee and completed application materials are  
366 not provided to the insurer, hospital [or] service corporation, medical  
367 service corporation or health care center before the expiration of the  
368 thirty-one-day period following the date the child was legally placed  
369 for adoption.

370 Sec. 22. Subdivision (5) of section 38a-564 of the general statutes is  
371 repealed and the following is substituted in lieu thereof (*Effective*  
372 *October 1, 2015*):

373 (5) "Insurer" means any insurance company, hospital [or] service  
374 corporation, medical service corporation [,] or health care center,  
375 authorized to transact health insurance business in this state.

376 Sec. 23. Subsection (b) of section 38a-577 of the general statutes is  
377 repealed and the following is substituted in lieu thereof (*Effective*  
378 *October 1, 2015*):

379 (b) The provisions of sections 38a-577 to 38a-590, inclusive, shall not  
380 apply to a licensed insurance company, [a] licensed hospital service  
381 corporation or licensed medical service corporation or a health  
382 [maintenance organization] care center.

383 Sec. 24. Subdivision (2) of section 38a-1040 of the general statutes is  
384 repealed and the following is substituted in lieu thereof (*Effective*  
385 *October 1, 2015*):

386 (2) "Managed care organization" means an insurer, health care  
387 center, hospital [or] service corporation, medical service corporation or  
388 other organization delivering, issuing for delivery, renewing or

389 amending any individual or group health managed care plan in this  
390 state.

391 Sec. 25. Section 18-52a of the general statutes is repealed and the  
392 following is substituted in lieu thereof (*Effective October 1, 2015*):

393 Any person committed to the custody of the Commissioner of  
394 Correction who is confined in a correctional facility and requires  
395 hospitalization for medical care may be transferred by the department  
396 to any hospital having facilities for such care. If such person is covered  
397 by a health insurance policy, as defined in section 38a-469, and such  
398 policy provides coverage for such hospitalization or medical care, such  
399 person shall be liable to the hospital for all covered expenses, and (1)  
400 such person shall arrange to have the carrier pay the amount of  
401 covered expenses to the hospital, or (2) if such policy indemnifies the  
402 covered person for costs incurred, such person shall pay the hospital  
403 for covered expenses. Each carrier shall provide benefits for covered  
404 expenses without regard to whether a person is committed to the  
405 custody of the Commissioner of Correction. If such person is not  
406 covered by a health insurance policy, the department shall reimburse  
407 the receiving hospital at a rate not to exceed that established under the  
408 provisions of section 17b-239. As used in this section, "carrier" means  
409 any insurance company, hospital [or] service corporation, medical  
410 service corporation, health care center, fraternal benefit society or other  
411 entity which delivers, issues for delivery or renews a health insurance  
412 policy in this state.

413 Sec. 26. Subdivision (4) of subsection (a) of section 20-7f of the  
414 general statutes is repealed and the following is substituted in lieu  
415 thereof (*Effective October 1, 2015*):

416 (4) "Managed care organization" means an insurer, health care  
417 center, hospital [or] service corporation, medical service corporation or  
418 other organization delivering, issuing for delivery, renewing or  
419 amending any individual or group health managed care plan in this

420 state.

421 Sec. 27. Subsection (d) of section 8-265ss of the general statutes is  
422 repealed and the following is substituted in lieu thereof (*Effective*  
423 *October 1, 2015*):

424 (d) A HERO loan shall: (1) Be a mortgage for up to thirty years in an  
425 amount determined by the authority; (2) provide an interest rate at an  
426 amount determined by the authority; (3) be serviced by the authority  
427 or its agents; and (4) have property taxes and insurance, including  
428 mortgage insurance, [homeowner's] homeowners insurance and, if  
429 applicable, flood insurance, included in the borrower's monthly  
430 payment amount.

431 Sec. 28. Subdivision (3) of subsection (a) of section 14-36m of the  
432 general statutes is repealed and the following is substituted in lieu  
433 thereof (*Effective October 1, 2015*):

434 (3) "Proof of residency" means a piece of mail or electronic mail that  
435 includes an applicant's name and address, indicates that such  
436 applicant resides in the state and is dated, unless otherwise indicated,  
437 not earlier than ninety days before an application for a motor vehicle  
438 operator's license, from any two of the following sources: (A) A bill  
439 from a bank or mortgage company, utility company, credit card  
440 company, doctor or hospital, (B) a bank statement or bank transaction  
441 receipt showing the bank's name and mailing address, (C) a preprinted  
442 pay stub, (D) a property or excise tax bill dated not earlier than twelve  
443 months before such application, (E) an annual benefits summary  
444 statement from the Social Security Administration or other pension or  
445 retirement plan dated not earlier than twelve months before such  
446 application, (F) a Medicaid or Medicare benefit statement, (G) a current  
447 [homeowner's] homeowners insurance or renter's insurance policy or  
448 motor vehicle insurance card or policy dated not earlier than twelve  
449 months before such application, (H) a residential mortgage or similar  
450 loan contract, lease or rental contract showing signatures from all

451 parties needed to execute the agreement dated not earlier than twelve  
452 months before such application, (I) any postmarked mail, (J) a change  
453 of address confirmation from the United States Postal Service  
454 indicating an applicant's current and prior address, (K) a survey of an  
455 applicant's real property issued by a licensed surveyor, or (L) any  
456 official school records showing enrollment.

457 Sec. 29. Section 36a-719h of the general statutes is repealed and the  
458 following is substituted in lieu thereof (*Effective October 1, 2015*):

459 No mortgage servicer shall:

460 (1) Directly or indirectly employ any scheme, device or artifice to  
461 defraud or mislead mortgagors or mortgagees or to defraud any  
462 person;

463 (2) Engage in any unfair or deceptive practice toward any person or  
464 misrepresent or omit any material information in connection with the  
465 servicing of the residential mortgage loan, including, but not limited  
466 to, misrepresenting the amount, nature or terms of any fee or payment  
467 due or claimed to be due on a residential mortgage loan, the terms and  
468 conditions of the servicing agreement or the mortgagor's obligations  
469 under the residential mortgage loan;

470 (3) Obtain property by fraud or misrepresentation;

471 (4) Knowingly misapply or recklessly apply residential mortgage  
472 loan payments to the outstanding balance of a residential mortgage  
473 loan;

474 (5) Knowingly misapply or recklessly apply payments to escrow  
475 accounts;

476 (6) Place hazard, [homeowner's] homeowners or flood insurance on  
477 the mortgaged property when the mortgage servicer knows or has  
478 reason to know that the mortgagor has an effective policy for such  
479 insurance;

480 (7) Fail to comply with section 49-10a;

481 (8) Knowingly or recklessly provide inaccurate information to a  
482 credit bureau, thereby harming a mortgagor's creditworthiness;

483 (9) Fail to report both the favorable and unfavorable payment  
484 history of the mortgagor to a nationally recognized consumer credit  
485 bureau at least annually if the mortgage servicer regularly reports  
486 information to a credit bureau;

487 (10) Collect private mortgage insurance beyond the date for which  
488 private mortgage insurance is required;

489 (11) Fail to issue a release of mortgage in accordance with section  
490 49-8;

491 (12) Fail to provide written notice to a mortgagor upon taking action  
492 to place hazard, [homeowner's] homeowners or flood insurance on the  
493 mortgaged property, including a clear and conspicuous statement of  
494 the procedures by which the mortgagor may demonstrate that he or  
495 she has the required insurance coverage and by which the mortgage  
496 servicer shall terminate the insurance coverage placed by it and refund  
497 or cancel any insurance premiums and related fees paid by or charged  
498 to the mortgagor;

499 (13) Place hazard, [homeowner's] homeowners or flood insurance  
500 on a mortgaged property, or require a mortgagor to obtain or maintain  
501 such insurance, in excess of the replacement cost of the improvements  
502 on the mortgaged property as established by the property insurer;

503 (14) Fail to provide to the mortgagor a refund of unearned  
504 premiums paid by a mortgagor or charged to the mortgagor for  
505 hazard, [homeowner's] homeowners or flood insurance placed by a  
506 mortgagee or the mortgage servicer if the mortgagor provides  
507 reasonable proof that the mortgagor has obtained coverage such that  
508 the forced placement insurance is no longer necessary and the

509 property is insured. If the mortgagor provides reasonable proof that no  
510 lapse in coverage occurred such that the forced placement was not  
511 necessary, the mortgage servicer shall promptly refund the entire  
512 premium;

513 (15) Require any amount of funds to be remitted by means more  
514 costly to the mortgagor than a bank or certified check or attorney's  
515 check from an attorney's account to be paid by the mortgagor;

516 (16) Refuse to communicate with an authorized representative of the  
517 mortgagor who provides a written authorization signed by the  
518 mortgagor, provided the mortgage servicer may adopt procedures  
519 reasonably related to verifying that the representative is in fact  
520 authorized to act on behalf of the mortgagor;

521 (17) Conduct any business covered by sections 36a-715 to 36a-719l,  
522 inclusive, without holding a valid license as required under said  
523 sections, or assist or aid and abet any person in the conduct of business  
524 without a valid license as required under this title;

525 (18) Negligently make any false statement or knowingly and  
526 wilfully make any omission of a material fact in connection with any  
527 information or reports filed with a governmental agency or the system  
528 or in connection with any investigation conducted by the Banking  
529 Commissioner or another governmental agency; or

530 (19) Collect, charge, attempt to collect or charge or use or propose  
531 any agreement purporting to collect or charge any fee prohibited by  
532 sections 36a-485 to 36a-498f, inclusive, 36a-534a and 36a-534b.

533 Sec. 30. Subdivision (1) of section 36a-760d of the general statutes is  
534 repealed and the following is substituted in lieu thereof (*Effective*  
535 *October 1, 2015*):

536 (1) With respect to nonprime home loans that are first mortgage  
537 loans for which the lender receives an application on or after April 1,

538 2010, the lender requires and collects a monthly escrow for the  
539 payment of real property taxes and [homeowner's] homeowners  
540 insurance. The provisions of this subdivision shall not apply to: (A)  
541 FHA loans; or (B) a nonprime home loan product which, in good faith,  
542 is generally designed and marketed to the public as a subordinate lien  
543 home equity loan product but is secured by a first mortgage loan;

544 Sec. 31. Subsection (b) of section 38a-12 of the general statutes is  
545 repealed and the following is substituted in lieu thereof (*Effective*  
546 *October 1, 2015*):

547 (b) On or before January [15, 2001, and] fifteenth annually,  
548 [thereafter,] the commissioner shall submit to the joint standing  
549 committee of the General Assembly having cognizance of matters  
550 relating to insurance a report, in accordance with the provisions of  
551 section 11-4a, detailing all the information the commissioner received  
552 during the past year pursuant to sections 29-311, 31-290d, 38a-356 and  
553 53-445.

554 Sec. 32. Subdivision (1) of subsection (b) of section 38a-58g of the  
555 general statutes is repealed and the following is substituted in lieu  
556 thereof (*Effective October 1, 2015*):

557 (b) (1) Such alien insurer shall enter into a domestication agreement  
558 in writing with a domestic insurer that provides for the domestic  
559 insurer to succeed to all the business and assets and to assume all the  
560 liabilities of the United States branch. The agreement shall be  
561 effectuated, upon approval by the commissioner, by the filing of an  
562 instrument of transfer and assumption as set forth in subdivision (4) of  
563 this [section] subsection.

564 Sec. 33. Section 38a-69 of the general statutes is repealed and the  
565 following is substituted in lieu thereof (*Effective October 1, 2015*):

566 Except as otherwise provided in this title, [38a,] sections 38a-11, 38a-  
567 50, 38a-52, 38a-70 to 38a-76, inclusive, 38a-81 to 38a-83, inclusive, and

568 38a-153, and the regulations adopted to implement said sections apply  
569 to all insurers, including reinsurers, licensed to do business in this  
570 state.

571 Sec. 34. Subdivision (5) of subsection (g) of section 38a-156a of the  
572 general statutes is repealed and the following is substituted in lieu  
573 thereof (*Effective October 1, 2015*):

574 (5) Policyholders of policies that confer the right to vote and are  
575 issued after the effective date by the reorganized insurer shall be  
576 members of and have equity rights in the mutual holding company.

577 Sec. 35. Subdivision (2) of subsection (a) of section 38a-156e of the  
578 general statutes is repealed and the following is substituted in lieu  
579 thereof (*Effective October 1, 2015*):

580 (2) Provide an alternative practice to subdivision (1) of this  
581 subsection that protects the contractual rights of individual  
582 policyholders of the reorganizing insurer with policies in force on the  
583 effective date, if the commissioner determines that such alternative is  
584 substantially as protective of the interests of individual participating  
585 policyholders as the establishment of a closed block pursuant to  
586 subdivision (1) of this [section] subsection.

587 Sec. 36. Section 38a-261 of the general statutes is repealed and the  
588 following is substituted in lieu thereof (*Effective October 1, 2015*):

589 A purchasing group [which] that intends to do business in this state  
590 shall furnish notice to the Insurance Commissioner [which] that shall:  
591 (1) Identify the state in which the group is domiciled; (2) specify the  
592 lines and classifications of liability insurance [which] that the  
593 purchasing group intends to purchase; (3) identify the insurance  
594 company from which the group intends to purchase its insurance and  
595 the domicile of such company; (4) identify the principal place of  
596 business of the group; (5) provide such other information as may be  
597 required by the Insurance Commissioner to verify that the purchasing

598 group satisfies the definitional requirements of subdivision (10) of  
599 section 38a-250; (6) register with and designate the Insurance  
600 Commissioner as its agent solely for the purpose of receiving service of  
601 legal documents or process, in accordance with Section 4 of the  
602 Liability Risk Retention Act of 1986; (7) identify all other states in  
603 which the group intends to do business; and (8) specify the method by  
604 which, and the person or persons, if any, through whom insurance will  
605 be offered to its members whose risks are resident or located in this  
606 state. A purchasing group shall [, within ten days,] notify the  
607 commissioner of any [changes] change in any of the items set forth in  
608 this section not later than ten days after any such change.

609 Sec. 37. Subsection (d) of section 38a-297 of the general statutes is  
610 repealed and the following is substituted in lieu thereof (*Effective*  
611 *October 1, 2015*):

612 (d) Any non-English-language policy shall be deemed to be in  
613 compliance with subsection (a) of this section if the insurer certifies  
614 that such policy is translated from an English-language policy [which]  
615 that complies with said subsection (a).

616 Sec. 38. Subdivision (4) of subsection (a) of section 38a-298 of the  
617 general statutes is repealed and the following is substituted in lieu  
618 thereof (*Effective October 1, 2015*):

619 (4) The sum of the figures computed under subdivisions (2) and (3)  
620 of this subsection subtracted from 206.835 equals the Flesch reading  
621 ease score for the policy form.

622 Sec. 39. Section 38a-307a of the general statutes is repealed and the  
623 following is substituted in lieu thereof (*Effective October 1, 2015*):

624 From July 1, 2004, until the expiration of the Terrorism Insurance  
625 Program established in the federal Terrorism Risk Insurance Act of  
626 2002, P.L. 107-297, as amended and reauthorized from time to time, (1)  
627 for any master policy that is required to be purchased by a

628 condominium association pursuant to section 47-83 or by a unit  
629 owners' association pursuant to section 47-255, the standard form of  
630 fire insurance policy set forth in section 38a-307 shall not exclude  
631 coverage for loss by fire or other perils insured against in the policy  
632 caused, directly or indirectly, by terrorism, as defined by the Insurance  
633 Commissioner; and (2) for any other commercial risk insurance policy,  
634 the standard form of fire insurance policy set forth in section 38a-307  
635 may provide that the company shall not be liable for loss by fire or  
636 other perils insured against in the policy caused, directly or indirectly,  
637 by terrorism, as defined by the Insurance Commissioner, provided the  
638 premiums charged for such policy shall reflect any savings projected  
639 from the exclusion of such perils.

640 Sec. 40. Subsection (f) of section 38a-322a of the general statutes is  
641 repealed and the following is substituted in lieu thereof (*Effective*  
642 *October 1, 2015*):

643 (f) The commissioner may conduct an investigation, pursuant to  
644 section 38a-16, of any person the commissioner reasonably believes has  
645 [been] violated or is engaged in a violation of any provision of this  
646 section.

647 Sec. 41. Section 38a-330 of the general statutes is repealed and the  
648 following is substituted in lieu thereof (*Effective October 1, 2015*):

649 Each property and casualty insurer [which] that, at the time of  
650 policy renewal, transfers any policy to an affiliate as a result of a  
651 merger or acquisition of control, shall provide notice to policyholders  
652 at least sixty days prior to the effective date of transfer. Such transfer  
653 shall not require a nonrenewal or cancellation of the policy.

654 Sec. 42. Section 38a-338 of the general statutes is repealed and the  
655 following is substituted in lieu thereof (*Effective October 1, 2015*):

656 Policies affording bodily injury liability, property damage liability  
657 and uninsured motorist coverages to which the provisions of sections

658 38a-334 to 38a-336a, inclusive, [38a-338] and 38a-340 apply shall be  
659 deemed to provide insurance under such coverages in accordance with  
660 [such] regulations adopted pursuant to section 38a-334. Policies  
661 affording medical payments coverage to which the provisions of said  
662 sections apply shall be deemed to provide insurance under such  
663 coverage in accordance with such regulations.

664 Sec. 43. Subsection (c) of section 38a-472 of the general statutes is  
665 repealed and the following is substituted in lieu thereof (*Effective*  
666 *October 1, 2015*):

667 (c) No insurer, health care center or issuer of any service plan  
668 contract for hospital or medical expense coverage delivered, issued for  
669 delivery or renewed in this state shall impose requirements on the  
670 Department of Social Services [which] that have the effect of denying  
671 or limiting benefits [which] that have been assigned pursuant to this  
672 section. The assignment of benefits shall be in accordance with the  
673 provisions of this section. [38a-472.]

674 Sec. 44. Section 38a-472a of the general statutes is repealed and the  
675 following is substituted in lieu thereof (*Effective October 1, 2015*):

676 No contract between a managed care company, other organization  
677 or insurer authorized to do business in this state and a medical  
678 provider practicing in this state for the provision of services may  
679 require that the medical provider indemnify the managed care  
680 company, other organization or insurer for any expenses and liabilities  
681 including, without limitation, judgments, settlements, attorneys' fees,  
682 court costs and any associated charges incurred in connection with any  
683 claim or action brought against a managed care company, other  
684 organization or insurer on the basis of its determination of medical  
685 necessity or appropriateness of health care services if the information  
686 provided by [said] such medical provider used in making the  
687 determination was accurate and appropriate at the time it was given.  
688 As used in this section and section 38a-472b, "medical provider" means

689 any person licensed pursuant to chapters 370 to 373, inclusive, or  
690 chapter 375, 379, 380 or 383.

691 Sec. 45. Subdivision (1) of subsection (a) of section 38a-478c of the  
692 general statutes is repealed and the following is substituted in lieu  
693 thereof (*Effective October 1, 2015*):

694 (1) A report on its quality assurance plan that includes, but is not  
695 limited to, information on complaints related to providers and quality  
696 of care, on decisions related to patient requests for coverage and on  
697 prior authorization statistics. Statistical information shall be submitted  
698 in a manner permitting comparison across plans and shall include, but  
699 not be limited to: (A) The ratio of the number of complaints received to  
700 the number of enrollees; (B) a summary of the complaints received  
701 related to providers and delivery of care or services and the action  
702 taken on the complaint; (C) the ratio of the number of prior  
703 authorizations denied to the number of prior authorizations requested;  
704 (D) the number of utilization review determinations made by or on  
705 behalf of a managed care organization not to certify an admission,  
706 service, procedure or extension of stay, and the denials upheld and  
707 reversed on appeal within the managed care organization's utilization  
708 review procedure; (E) the percentage of those employers or groups  
709 that renew their contracts within the previous twelve months; and (F)  
710 notwithstanding the provisions of this subsection, on or before July  
711 first of each year, all data required by the National Committee for  
712 Quality Assurance [(NCQA)] for its Health Plan Employer Data and  
713 Information Set\_ [(HEDIS).] If an organization does not provide  
714 information for the National Committee for Quality Assurance for its  
715 Health Plan Employer Data and Information Set, then it shall provide  
716 such other equivalent data as the commissioner may require by  
717 regulations adopted in accordance with the provisions of chapter 54.  
718 The commissioner shall find that the requirements of this subdivision  
719 have been met if the managed care plan has received a one-year or  
720 higher level of accreditation by the National Committee for Quality  
721 Assurance and has submitted the Health Plan Employee Data

722 Information Set data required by subparagraph (F) of this subdivision;

723 Sec. 46. Subdivision (4) of subsection (a) of section 38a-478c of the  
724 general statutes is repealed and the following is substituted in lieu  
725 thereof (*Effective October 1, 2015*):

726 (4) Such information as the commissioner deems necessary to  
727 complete the consumer report card required pursuant to section 38a-  
728 478l, as amended by this act. Such information may include, but need  
729 not be limited to: (A) The organization's characteristics, including its  
730 model, its profit or nonprofit status, its address and telephone number,  
731 the length of time it has been licensed in this and any other state, its  
732 number of enrollees and whether it has received any national or  
733 regional accreditation; (B) a summary of the information required by  
734 subdivision (3) of this [section] subsection, including any change in a  
735 plan's rates over the prior three years, its state medical loss ratio and  
736 its federal medical loss ratio, as both terms are defined in section 38a-  
737 478l, as amended by this act, how it compensates health care providers  
738 and its premium level; (C) a description of services, the number of  
739 primary care physicians and specialists, the number and nature of  
740 participating preferred provider networks and the distribution and  
741 number of hospitals, by county; (D) utilization review information,  
742 including the name or source of any established medical protocols and  
743 the utilization review standards; (E) medical management information,  
744 including the provider-to-patient ratio by primary care provider and  
745 specialty care provider, the percentage of primary and specialty care  
746 providers who are board certified, and how the medical protocols  
747 incorporate input as required in section 38a-478e; (F) the quality  
748 assurance information required to be submitted under the provisions  
749 of subdivision (1) of subsection (a) of this section; (G) the status of the  
750 organization's compliance with the reporting requirements of this  
751 section; (H) whether the organization markets to individuals and  
752 Medicare recipients; (I) the number of hospital days per thousand  
753 enrollees; and (J) the average length of hospital stays for specific  
754 procedures, as may be requested by the commissioner;

755 Sec. 47. Subdivision (14) of subsection (b) of section 38a-478g of the  
756 general statutes is repealed and the following is substituted in lieu  
757 thereof (*Effective October 1, 2015*):

758 (14) The status of the National Committee for Quality Assurance  
759 [(NCQA)] accreditation;

760 Sec. 48. Subsection (c) of section 38a-478l of the general statutes is  
761 repealed and the following is substituted in lieu thereof (*Effective*  
762 *October 1, 2015*):

763 (c) With respect to mental health services, the consumer report card  
764 shall include information or measures with respect to the percentage of  
765 enrollees receiving mental health services, utilization of mental health  
766 and chemical dependence services, inpatient and outpatient  
767 admissions, discharge rates and average lengths of stay. Such data  
768 shall be collected in a manner consistent with the National Committee  
769 for Quality Assurance Health Plan Employer Data and Information Set  
770 [(HEDIS)] measures.

771 Sec. 49. Subsection (c) of section 38a-478r of the general statutes is  
772 repealed and the following is substituted in lieu thereof (*Effective*  
773 *October 1, 2015*):

774 (c) For the purposes of this section, in accordance with the National  
775 Committee for Quality Assurance, an emergency medical condition is  
776 a condition such that a prudent [lay-person] layperson, acting  
777 reasonably, would have believed that emergency medical treatment is  
778 needed.

779 Sec. 50. Subsections (a) to (c), inclusive, of section 38a-481 of the  
780 general statutes are repealed and the following is substituted in lieu  
781 thereof (*Effective October 1, 2015*):

782 (a) No individual health insurance policy shall be delivered or  
783 issued for delivery to any person in this state, nor shall any

784 application, rider or endorsement be used in connection with such  
785 policy, until a copy of the form thereof and of the classification of risks  
786 and the premium rates have been filed with the commissioner. Rate  
787 filings shall include an actuarial memorandum that includes, but is not  
788 limited to, pricing assumptions and claims experience, premium rates  
789 and loss ratios from the inception of the policy. The commissioner shall  
790 adopt regulations, in accordance with the provisions of chapter 54, to  
791 establish a procedure for reviewing such policies. The commissioner  
792 shall disapprove the use of such form at any time if it does not comply  
793 with the requirements of law, or if it contains a provision or provisions  
794 [which] that are unfair or deceptive or [which] that encourage  
795 misrepresentation of the policy. The commissioner shall notify, in  
796 writing, the insurer [which] that has filed any such form of the  
797 commissioner's disapproval, specifying the reasons for disapproval,  
798 and ordering that no such insurer shall deliver or issue for delivery to  
799 any person in this state a policy on or containing such form. The  
800 provisions of section 38a-19 shall apply to such orders.

801 (b) No rate filed under the provisions of subsection (a) of this  
802 section shall be effective until it has been [filed and] approved by the  
803 commissioner in accordance with regulations adopted pursuant to this  
804 subsection. The commissioner shall adopt regulations, in accordance  
805 with the provisions of chapter 54, to prescribe standards to ensure that  
806 such rates shall not be excessive, inadequate or unfairly  
807 discriminatory. The commissioner may disapprove such rate within  
808 thirty days after it has been filed if it fails to comply with such  
809 standards, except that no rate filed under the provisions of subsection  
810 (a) of this section for any Medicare supplement policy shall be effective  
811 unless approved in accordance with section 38a-474.

812 (c) No insurance company, fraternal benefit society, hospital service  
813 corporation, medical service corporation, health care center or other  
814 entity [which] that delivers or issues for delivery in this state any  
815 Medicare supplement policies or certificates shall incorporate in its  
816 rates or determinations to grant coverage for Medicare supplement

817 insurance policies or certificates any factors or values based on the age,  
818 gender, previous claims history or the medical condition of any person  
819 covered by such policy or certificate.

820 Sec. 51. Subsections (a) and (b) of section 38a-513 of the general  
821 statutes are repealed and the following is substituted in lieu thereof  
822 (*Effective October 1, 2015*):

823 (a) No group health insurance policy, as defined by the  
824 commissioner, or certificate shall be [issued or] delivered or issued for  
825 delivery in this state unless a copy of the form for such policy or  
826 certificate has been submitted to and approved by the commissioner  
827 under the regulations adopted pursuant to this section. The  
828 commissioner shall adopt regulations, in accordance with the  
829 provisions of chapter 54, concerning the provisions, submission and  
830 approval of such policies and certificates and establishing a procedure  
831 for reviewing such policies and certificates. If the commissioner issues  
832 an order disapproving the use of such form, the provisions of section  
833 38a-19 shall apply to such order.

834 (b) No insurance company, fraternal benefit society, hospital service  
835 corporation, medical service corporation, health care center or other  
836 entity [which] that delivers or issues for delivery in this state any  
837 Medicare supplement policies or certificates shall incorporate in its  
838 rates or determinations to grant coverage for Medicare supplement  
839 insurance policies or certificates any factors or values based on the age,  
840 gender, previous claims history or the medical condition of any person  
841 covered by such policy or certificate.

842 Sec. 52. Section 38a-503c of the general statutes is repealed and the  
843 following is substituted in lieu thereof (*Effective October 1, 2015*):

844 (a) As used in this section, "carrier" means each insurer, health care  
845 center, hospital service corporation, medical service corporation or  
846 other entity delivering, issuing for delivery, renewing, amending or  
847 continuing any individual health insurance policy in this state

848 providing coverage of the type specified in subdivisions (1), (2), (4), (6),  
849 (10), (11) and (12) of section 38a-469.

850 (b) Each individual health insurance carrier that offers maternity  
851 benefits shall provide coverage of a minimum of forty-eight hours of  
852 inpatient care for a mother and her newborn infant following a vaginal  
853 delivery and a minimum of ninety-six hours of inpatient care for a  
854 mother and her newborn infant following a caesarean delivery. The  
855 time periods shall commence at the time of delivery.

856 (c) Any decision to shorten the length of inpatient stay to less than  
857 that provided under subsection (b) of this section shall be made by the  
858 attending health care providers after conferring with the mother.

859 (d) If a mother and newborn are discharged pursuant to subsection  
860 (c) of this section, prior to the inpatient length of stay provided under  
861 subsection (b) of this section, coverage shall be provided for a follow-  
862 up visit within forty-eight hours of discharge and an additional follow-  
863 up visit within seven days of discharge. Such follow-up services shall  
864 include, but not be limited to, physical assessment of the newborn,  
865 parent education, assistance and training in breast or bottle feeding,  
866 assessment of the home support system and the performance of any  
867 medically necessary and appropriate clinical tests. Such services shall  
868 be consistent with protocols and guidelines developed by attending  
869 providers or by national pediatric, obstetric and nursing professional  
870 organizations for these services and shall be provided by qualified  
871 health care personnel trained in postpartum maternal and newborn  
872 pediatric care.

873 [(e) Each individual health insurance carrier shall provide notice to  
874 policyholders regarding the coverage required under this section. The  
875 notice shall be in writing and shall be transmitted at the earliest of  
876 either the next mailing to the policyholder, the yearly summary of  
877 benefits sent to the policyholder or January 1, 1997.]

878 Sec. 53. Section 38a-530c of the general statutes is repealed and the

879 following is substituted in lieu thereof (*Effective October 1, 2015*):

880 (a) As used in this section, "carrier" means each insurer, health care  
881 center, hospital service corporation, medical service corporation or  
882 other entity delivering, issuing for delivery, renewing, amending or  
883 continuing any group health insurance policy in this state providing  
884 coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11)  
885 and (12) of section 38a-469.

886 (b) Each group insurance carrier that offers maternity benefits shall  
887 provide coverage of a minimum of forty-eight hours of inpatient care  
888 for a mother and her newborn infant following a vaginal delivery and  
889 a minimum of ninety-six hours of inpatient care for a mother and her  
890 newborn infant following a caesarean delivery. The time periods shall  
891 commence at the time of delivery.

892 (c) Any decision to shorten the length of inpatient stay to less than  
893 that provided under subsection (b) of this section shall be made by the  
894 attending health care providers after conferring with the mother.

895 (d) If a mother and newborn are discharged pursuant to subsection  
896 (c) of this section, prior to the inpatient length of stay provided under  
897 subsection (b) of this section, coverage shall be provided for a follow-  
898 up visit within forty-eight hours of discharge and an additional follow-  
899 up visit within seven days of discharge. Such follow-up services shall  
900 include, but not be limited to, physical assessment of the newborn,  
901 parent education, assistance and training in breast or bottle feeding,  
902 assessment of the home support system and the performance of any  
903 medically necessary and appropriate clinical tests. Such services shall  
904 be consistent with protocols and guidelines developed by attending  
905 providers or by national pediatric, obstetric and nursing professional  
906 organizations for these services and shall be provided by qualified  
907 health care personnel trained in postpartum maternal and newborn  
908 pediatric care.

909 [(e) Each group insurance carrier shall provide notice to

910 policyholders regarding the coverage required under this section. The  
911 notice shall be in writing and shall be transmitted at the earliest of  
912 either the next mailing to the policyholder, the yearly summary of  
913 benefits sent to the policyholder or January 1, 1997.]

914 Sec. 54. Subparagraph (H) of subdivision (1) of subsection (e) of  
915 section 38a-591d of the general statutes is repealed and the following is  
916 substituted in lieu thereof (*Effective October 1, 2015*):

917 (H) A statement explaining the right of the covered person to  
918 contact the commissioner's office or the Office of the Healthcare  
919 Advocate at any time for assistance or, upon completion of the health  
920 carrier's internal grievance process, to file a civil ~~[suit]~~ action in a court  
921 of competent jurisdiction. Such statement shall include the contact  
922 information for said offices; and

923 Sec. 55. Section 38a-663 of the general statutes is repealed and the  
924 following is substituted in lieu thereof (*Effective October 1, 2015*):

925 The following words and phrases, as used in sections 38a-663 to  
926 38a-696, inclusive, as amended by this act, shall have the following  
927 meanings unless the context otherwise requires:

928 ~~[(a)]~~ (1) "Rating organization" means an individual, partnership,  
929 corporation, unincorporated association, other than an admitted  
930 insurer, whether located within or outside this state, who or ~~[which]~~  
931 that has as a primary object or purpose the making of rates, rating  
932 plans or rating systems. Two or more admitted insurers ~~[which]~~ that  
933 act in concert for the purpose of making rates, rating plans or rating  
934 systems, and ~~[which]~~ that do not operate within the specific  
935 authorizations contained in sections 38a-667, 38a-669, 38a-670 and 38a-  
936 672 shall be deemed to be a rating organization. No single insurer shall  
937 be deemed to be a rating organization.

938 ~~[(b)]~~ (2) "Advisory organization" means every group, association or  
939 other organization of insurers, whether located within or outside this

940 state, [which] that assists insurers or rating organizations in rate-  
941 making by the collection and furnishing of loss or expense statistics, or  
942 by the submission of recommendations, provided the term shall not  
943 include actuarial, legal or other consultants.

944 [(c)] (3) "Member" means an insurer [who] that participates in or is  
945 entitled to participate in the management of a rating, advisory or other  
946 organization.

947 [(d)] (4) "Subscriber" means an insurer [which] that is furnished at  
948 its request [(1)] (A) with rates and rating manuals by a rating  
949 organization of which it is not a member, or [(2)] (B) with advisory  
950 services by an advisory organization of which it is not a member.

951 [(e)] (5) "Wilful" and "wilfully" in relation to an act or omission  
952 [which] that constitutes a violation of sections 38a-663 to 38a-681,  
953 inclusive, as amended by this act, means with actual knowledge or  
954 belief that such act or omission constitutes such violation and with  
955 specific intent to commit such violation.

956 [(f)] (6) "Market" means the interaction between buyers and sellers  
957 consisting of a product market component and a geographic market  
958 component, as determined by the commissioner in accordance with the  
959 provisions of subsection (b) of section 38a-687.

960 [(g)] (7) "Noncompetitive market" means a residual market or a  
961 market for which there is a ruling in effect pursuant to section 38a-687,  
962 that a reasonable degree of competition does not exist.

963 [(h)] (8) "Competitive market" means a market [which] that has not  
964 been found to be noncompetitive pursuant to section 38a-687.

965 [(i)] (9) "Personal risk insurance" means homeowners, tenants,  
966 private passenger nonfleet automobile, mobile manufactured home  
967 and other property and casualty insurance for personal, family or  
968 household needs except workers' compensation insurance.

969 [(j)] (10) "Commercial risk insurance" means insurance within the  
970 scope of sections 38a-663 to 38a-696, inclusive, [which] as amended by  
971 this act, that is not personal risk insurance.

972 [(k)] (11) "Supplementary rate information" includes any manual or  
973 plan of rates, classification, rating schedule, minimum premium, rating  
974 rule, and any other similar information needed to determine the  
975 applicable rate in effect or to be in effect.

976 [(l)] (12) "Supporting information" means [(1)] (A) the experience  
977 and judgment of the filer and the experience or data of other insurers  
978 or organizations relied upon by the filer, [(2)] (B) the interpretation of  
979 any statistical data relied upon by the filer, and [(3)] (C) descriptions of  
980 methods used in making the rates, and other similar information  
981 required to be filed by the commissioner.

982 [(m)] (13) "Residual market" means an arrangement for the  
983 provision of insurance in accordance with the provisions of section  
984 38a-328, 38a-329 or 38a-670.

985 Sec. 56. Section 38a-740 of the general statutes is repealed and the  
986 following is substituted in lieu thereof (*Effective October 1, 2015*):

987 The commissioner may by regulation adopted in accordance with  
988 the provisions of chapter 54: (1) Establish such proper standards as [he  
989 may deem] the commissioner deems necessary to guide surplus lines  
990 brokers procuring any such policy of insurance, as is permitted under  
991 subsection (a) of section 38a-794, from any such unauthorized insurer;  
992 (2) require any unauthorized insurer from which any surplus lines  
993 broker has procured or intends to procure any policy of insurance, as  
994 is permitted under subsection (a) of section 38a-794, to file with [him]  
995 the commissioner such evidence and in such form as [he may prescribe  
996 so as] the commissioner prescribes to enable [him] the commissioner to  
997 establish the financial stability, qualifications and general suitability of  
998 such unauthorized insurer to issue any policy of insurance through  
999 any surplus lines broker, under section 38a-794; and (3) establish such

1000 reasonable filing fees as may be necessary to defray the cost [to him] of  
1001 examining evidence filed with [him] the commissioner by an  
1002 unauthorized insurer either voluntarily or pursuant to the provisions  
1003 of this section.

1004 Sec. 57. Section 38a-742 of the general statutes is repealed and the  
1005 following is substituted in lieu thereof (*Effective October 1, 2015*):

1006 The licensee shall keep a complete and separate record of all policies  
1007 procured from unauthorized insurers under such license. Such records  
1008 shall be open to the examination of the commissioner at all reasonable  
1009 times and shall show: (1) The exact amount of each kind of insurance  
1010 permitted under sections 38a-741 to 38a-744, inclusive, and 38a-794  
1011 that has been procured for each insured; (2) the gross premiums  
1012 charged by the insurers for each kind of insurance permitted under  
1013 section 38a-794; (3) the amount of each kind of premiums of insurance  
1014 permitted by section 38a-794 [which] that were returned to each  
1015 insured; (4) the name of the insurer or insurers [which] that issued  
1016 each of such policies; (5) the effective dates of such policies; and (6) the  
1017 terms for which they were issued.

1018 Sec. 58. Subsection (b) of section 38a-940 of the general statutes is  
1019 repealed and the following is substituted in lieu thereof (*Effective*  
1020 *October 1, 2015*):

1021 (b) Whether or not the third party files a claim, the insured may file  
1022 a claim on the insured's own behalf in the liquidation. To the extent the  
1023 insured files a claim, it shall be deemed sufficient to cover all related  
1024 third party claims. If the insured fails to file a claim by the date for  
1025 filing claims specified in the order of liquidation or within sixty days  
1026 after mailing of the notice required by section 38a-924, whichever is  
1027 later, the [insurer] insured shall be deemed an unexcused late filer.

1028 Sec. 59. Subsection (a) of section 38a-1051 of the general statutes is  
1029 repealed and the following is substituted in lieu thereof (*Effective*  
1030 *October 1, 2015*):

1031 (a) Whereas the General Assembly finds that: (1) Equal enjoyment of  
1032 the highest attainable standard of health is a human right and a  
1033 priority of the state, (2) research and experience demonstrate that  
1034 inhabitants of the state experience barriers to the equal enjoyment of  
1035 good health based on race, ethnicity, gender, national origin and  
1036 linguistic ability, and (3) addressing such barriers, and others that may  
1037 arise in the future, requires: The collection, analysis and reporting of  
1038 information, the identification of causes, and the development and  
1039 implementation of policy solutions that address health disparities  
1040 while improving the health of the public as a whole therefore, there is  
1041 established a Commission on Health Equity with the mission of  
1042 eliminating disparities in health status based on race, ethnicity, gender  
1043 and linguistic ability, and improving the quality of health for all of the  
1044 state's residents. Such commission shall consist of the following  
1045 commissioners, or their designees, and public members: (A) The  
1046 Commissioners of Public Health, Mental Health and Addiction  
1047 Services, Developmental Services, Social Services, Correction, Children  
1048 and Families, and Education; (B) the dean of The University of  
1049 Connecticut Health Center, or his or her designee; (C) the director of  
1050 The University of Connecticut Health Center and Center for Public  
1051 Health and Health Policy, or their designees; (D) the dean of the Yale  
1052 University Medical School, or his or her designee; (E) the dean of  
1053 [Public Health and the School of Epidemiology at Yale University] the  
1054 Yale School of Public Health, or his or her designee; (F) one member  
1055 appointed by the president pro tempore of the Senate, who shall be a  
1056 member of an affiliate of the National Urban League; (G) one member  
1057 appointed by the speaker of the House of Representatives, who shall  
1058 be a member of the National Association for the Advancement of  
1059 Colored People; (H) one member appointed by the majority leader of  
1060 the House of Representatives, who shall be a member of the Black and  
1061 Puerto Rican Caucus of the General Assembly; (I) one member  
1062 appointed by the majority leader of the Senate with the advice of the  
1063 Native American Heritage Advisory Council or the chairperson of the  
1064 Indian Affairs Council, who shall be a representative of the Native

1065 American community; (J) one member appointed by the minority  
1066 leader of the Senate, who shall be a representative of an advocacy  
1067 group for Hispanics; (K) one member appointed by the minority leader  
1068 of the House of Representatives, who shall be a representative of the  
1069 state-wide Multicultural Health Network; (L) the chairperson of the  
1070 African-American Affairs Commission, or his or her designee; (M) the  
1071 chairperson of the Latino and Puerto Rican Affairs Commission, or his  
1072 or her designee; (N) the chairperson of the Permanent Commission on  
1073 the Status of Women, or his or her designee; (O) the chairperson of the  
1074 Asian Pacific American Affairs Commission, or his or her designee; (P)  
1075 the director of the Hispanic Health Council, or his or her designee; (Q)  
1076 [the chairperson of the Office of] the Healthcare Advocate, or his or her  
1077 designee; and (R) eight members of the public, representing  
1078 communities facing disparities in health status based on race, ethnicity,  
1079 gender and linguistic ability, who shall be appointed as follows: Two  
1080 by the president pro tempore of the Senate, two by the speaker of the  
1081 House of Representatives, two by the minority leader of the Senate,  
1082 and two by the minority leader of the House of Representatives.  
1083 Vacancies on the council shall be filled by the appointing authority.

1084 Sec. 60. Section 38a-1080 of the general statutes is repealed and the  
1085 following is substituted in lieu thereof (*Effective October 1, 2015*):

1086 For purposes of sections 38a-1080 to [38a-1091] 38a-1092, inclusive,  
1087 as amended by this act:

1088 (1) "Board" means the board of directors of the Connecticut Health  
1089 Insurance Exchange;

1090 (2) "Commissioner" means the Insurance Commissioner;

1091 (3) "Exchange" means the Connecticut Health Insurance Exchange  
1092 established pursuant to section 38a-1081, as amended by this act;

1093 (4) "Affordable Care Act" means the Patient Protection and  
1094 Affordable Care Act, P.L. 111-148, as amended by the Health Care and

1095 Education Reconciliation Act, P.L. 111-152, as both may be amended  
1096 from time to time, and regulations adopted thereunder;

1097 (5) (A) "Health benefit plan" means an insurance policy or contract  
1098 offered, delivered, issued for delivery, renewed, amended or  
1099 continued in the state by a health carrier to provide, deliver, pay for or  
1100 reimburse any of the costs of health care services.

1101 (B) "Health benefit plan" does not include:

1102 (i) Coverage of the type specified in subdivisions (5), (6), (7), (8), (9),  
1103 (14), (15) and (16) of section 38a-469 or any combination thereof;

1104 (ii) Coverage issued as a supplement to liability insurance;

1105 (iii) Liability insurance, including general liability insurance and  
1106 automobile liability insurance;

1107 (iv) Workers' compensation insurance;

1108 (v) Automobile medical payment insurance;

1109 (vi) Credit insurance;

1110 (vii) Coverage for on-site medical clinics; or

1111 (viii) Other similar insurance coverage specified in regulations  
1112 issued pursuant to the Health Insurance Portability and Accountability  
1113 Act of 1996, P.L. 104-191, as amended from time to time, under which  
1114 benefits for health care services are secondary or incidental to other  
1115 insurance benefits.

1116 (C) "Health benefit plan" does not include the following benefits if  
1117 they are provided under a separate insurance policy, certificate or  
1118 contract or are otherwise not an integral part of the plan:

1119 (i) Limited scope dental or vision benefits;

1120 (ii) Benefits for long-term care, nursing home care, home health  
1121 care, community-based care or any combination thereof; or

1122 (iii) Other similar, limited benefits specified in regulations issued  
1123 pursuant to the Health Insurance Portability and Accountability Act of  
1124 1996, P.L. 104-191, as amended from time to time;

1125 (iv) Other supplemental coverage, similar to coverage of the type  
1126 specified in subdivisions (9) and (14) of section 38a-469, provided  
1127 under a group health plan.

1128 (D) "Health benefit plan" does not include coverage of the type  
1129 specified in subdivisions (3) and (13) of section 38a-469 or other fixed  
1130 indemnity insurance if (i) such coverage is provided under a separate  
1131 insurance policy, certificate or contract, (ii) there is no coordination  
1132 between the provision of the benefits and any exclusion of benefits  
1133 under any group health plan maintained by the same plan sponsor,  
1134 and (iii) the benefits are paid with respect to an event without regard  
1135 to whether benefits were also provided under any group health plan  
1136 maintained by the same plan sponsor;

1137 (6) "Health care services" has the same meaning as provided in  
1138 section 38a-478, as amended by this act;

1139 (7) "Health carrier" means an insurance company, fraternal benefit  
1140 society, hospital service corporation, medical service corporation,  
1141 health care center or other entity subject to the insurance laws and  
1142 regulations of the state or the jurisdiction of the commissioner that  
1143 contracts or offers to contract to provide, deliver, pay for or reimburse  
1144 any of the costs of health care services;

1145 (8) "Internal Revenue Code" means the Internal Revenue Code of  
1146 1986, or any subsequent corresponding internal revenue code of the  
1147 United States, as amended from time to time;

1148 (9) "Person" has the same meaning as provided in section 38a-1;

1149 (10) "Qualified dental plan" means a limited scope dental plan that  
1150 has been certified in accordance with subsection (e) of section 38a-1086;

1151 (11) "Qualified employer" has the same meaning as provided in  
1152 Section 1312 of the Affordable Care Act;

1153 (12) "Qualified health plan" means a health benefit plan that has in  
1154 effect a certification that the plan meets the criteria for certification  
1155 described in Section 1311(c) of the Affordable Care Act and section  
1156 38a-1086;

1157 (13) "Qualified individual" has the same meaning as provided in  
1158 Section 1312 of the Affordable Care Act;

1159 (14) "Secretary" means the Secretary of the United States  
1160 Department of Health and Human Services;

1161 (15) "Small employer" has the same meaning as provided in section  
1162 38a-564, as amended by this act.

1163 Sec. 61. Subdivisions (3) and (4) of subsection (c) of section 38a-1081  
1164 of the general statutes are repealed and the following is substituted in  
1165 lieu thereof (*Effective October 1, 2015*):

1166 (3) Appointed board members may not designate a representative to  
1167 perform in their absence their respective duties under sections 38a-  
1168 1080 to [38a-1091] 38a-1092, inclusive, as amended by this act. The  
1169 Governor shall select a chairperson from among the board members  
1170 and the board members shall annually elect a vice-chairperson.  
1171 Meetings of the board of directors shall be held at such times as shall  
1172 be specified in the bylaws adopted by the board and at such other time  
1173 or times as the chairperson deems necessary. Any board member who  
1174 fails to attend more than fifty per cent of all meetings held during any  
1175 calendar year shall be deemed to have resigned from the board.

1176 (4) Six board members shall constitute a quorum for the transaction  
1177 of any business or the exercise of any power of the exchange. For the

1178 transaction of any business or the exercise of any power of the  
1179 exchange, the exchange may act by a majority of the board members  
1180 present at any meeting at which a quorum is in attendance. No  
1181 vacancy in the membership of the board of directors shall impair the  
1182 right of such board members to exercise all the rights and perform all  
1183 the duties of the board. Except as otherwise provided in sections 38a-  
1184 1080 to 38a-1092, inclusive, as amended by this act, any action taken by  
1185 the board under the provisions of sections 38a-1080 to [38a-1091] 38a-  
1186 1092, inclusive, as amended by this act, may be authorized by  
1187 resolution approved by a majority of the board members present at  
1188 any regular or special meeting, which resolution shall take effect  
1189 immediately unless otherwise provided in the resolution.

1190 Sec. 62. Subparagraph (B) of subdivision (3) of subsection (b) of  
1191 section 38a-1091 of the general statutes is repealed and the following is  
1192 substituted in lieu thereof (*Effective October 1, 2015*):

1193 (B) The chief executive officer of the exchange may provide the  
1194 name of any reporting entity on which such penalty has been imposed  
1195 to the commissioner. After consultation with said officer, the  
1196 commissioner may request the Attorney General to bring an action in  
1197 the superior court for the judicial district of Hartford to recover any  
1198 penalty imposed pursuant to subparagraph (A) of this subdivision.

1199 Sec. 63. Section 38a-1092 of the general statutes is repealed and the  
1200 following is substituted in lieu thereof (*Effective October 1, 2015*):

1201 (a) Not later than March 31, 2014, and quarterly thereafter, the  
1202 [Connecticut Health Insurance Exchange] exchange board of directors  
1203 [, established pursuant to section 38a-1081,] shall report to the joint  
1204 standing committees of the General Assembly having cognizance of  
1205 matters relating to public health, human services and insurance  
1206 concerning health care services provided through the exchange. Such  
1207 reports shall include: (1) The number of persons in households with  
1208 incomes from one hundred thirty-three per cent up to one hundred

1209 fifty per cent of the federal poverty level who were enrolled in a  
1210 qualified health plan at any time on or after January 1, 2014; (2) the  
1211 number of persons in households with incomes from one hundred fifty  
1212 per cent up to and including two hundred per cent of the federal  
1213 poverty level who were enrolled in a qualified health plan at any time  
1214 on and after January 1, 2014; (3) the number of persons in households  
1215 with incomes from one hundred thirty-three per cent up to and  
1216 including two hundred per cent of the federal poverty level who have  
1217 been continuously enrolled in a qualified health plan during the  
1218 current calendar year; (4) the number of persons in households with  
1219 incomes from one hundred thirty-three per cent up to and including  
1220 two hundred per cent of the federal poverty level who were enrolled in  
1221 a qualified health plan and who subsequently became eligible to  
1222 receive benefits under the Medicaid program or whose household  
1223 income increased to more than two hundred per cent of the federal  
1224 poverty level; (5) the number of persons in households with incomes  
1225 from one hundred thirty-three per cent up to and including two  
1226 hundred per cent of the federal poverty level who experienced a gap in  
1227 health care coverage; (6) the cost to the state of providing health care  
1228 services to persons identified in subdivision (5) of this subsection and  
1229 the cost to such persons to access health care coverage through the  
1230 exchange; (7) the cost of the second-lowest-priced silver premium plan  
1231 in the exchange; and (8) any other information that said board believes  
1232 would be necessary to allow said committees to evaluate the cost and  
1233 benefits of a basic health plan.

1234 (b) The [Connecticut Health Insurance Exchange] exchange board of  
1235 directors shall include in the first quarterly report submitted each year  
1236 to said committees in accordance with subsection (a) of this section, the  
1237 number of persons in households with incomes from one hundred  
1238 thirty-three up to and including two hundred per cent of the federal  
1239 poverty level who were enrolled in a qualified health plan at the end of  
1240 the previous calendar year.

1241 Sec. 64. Section 52-549n of the general statutes is repealed and the

1242 following is substituted in lieu thereof (*Effective October 1, 2015*):

1243 In accordance with the provisions of section 51-14, the judges of the  
1244 Superior Court may make such rules as they deem necessary to  
1245 provide a procedure in accordance with which the court, in its  
1246 discretion, may refer to a fact-finder for proceedings authorized  
1247 pursuant to this chapter, any contract action pending in the Superior  
1248 Court, except claims under insurance contracts for uninsured and [or]  
1249 underinsured motorist coverage, in which only money damages are  
1250 claimed and which is based upon an express or implied promise to pay  
1251 a definite sum, and in which the amount, legal interest or property in  
1252 controversy is less than fifty thousand dollars exclusive of interest and  
1253 costs. Such cases may be referred to a fact-finder only after the  
1254 certificate of closed pleadings has been filed, no claim for a jury trial  
1255 has been filed at the time of reference, and the time prescribed in  
1256 section 52-215 for filing a jury trial claim within thirty days of the  
1257 return day or within ten days after the issue of fact has been joined has  
1258 expired.

1259 Sec. 65. Subsection (a) of section 38a-199 of the general statutes is  
1260 repealed and the following is substituted in lieu thereof (*Effective*  
1261 *October 1, 2015*):

1262 (a) A hospital service corporation is defined as a non-profit-sharing  
1263 corporation without capital stock organized under the laws of the state  
1264 for the purpose of establishing, maintaining and operating a plan  
1265 whereby comprehensive health care, which shall include inpatient and  
1266 outpatient hospital care and home care, provided and billed by an  
1267 approved general, special or chronic disease hospital, an approved  
1268 clinic or an approved chronic and convalescent nursing home, and  
1269 services incidental thereto, may be provided, at the expense of said  
1270 corporation, to subscribers to such plan under a contract entitling such  
1271 subscribers to the benefits provided therein. When so determined by  
1272 any such corporation comprehensive health care shall also include  
1273 appliances, drugs, medicines, supplies and all other health goods and

1274 services, including the services of physicians, doctors of dentistry and  
1275 other licensed practitioners of the healing arts. Each such corporation  
1276 shall be governed by sections 38a-199 to 38a-209, inclusive, and shall,  
1277 except as [specifically designated herein] otherwise provided in this  
1278 title, be exempt from the provisions of the general statutes relating to  
1279 insurance. The provisions of sections 38a-815 to 38a-819, inclusive,  
1280 except subdivision (9) of section 38a-816, shall be applicable to such  
1281 corporation. Such hospitals, clinics and chronic and convalescent  
1282 nursing homes as shall be contained in a list of approved institutions  
1283 maintained by the Department of Public Health shall be deemed  
1284 approved for the purposes of sections 38a-199 to 38a-209, inclusive.

1285 Sec. 66. Subsection (a) of section 38a-214 of the general statutes is  
1286 repealed and the following is substituted in lieu thereof (*Effective*  
1287 *October 1, 2015*):

1288 (a) A nonprofit medical service corporation is defined as a non-  
1289 profit-sharing corporation without capital stock organized under the  
1290 laws of the state for the purpose of establishing, maintaining and  
1291 operating a plan whereby comprehensive health care, which shall  
1292 include inpatient and outpatient hospital care and home care,  
1293 provided and billed by an approved general, special or chronic disease  
1294 hospital, an approved clinic or an approved chronic and convalescent  
1295 nursing home and services incidental thereto may be provided, at the  
1296 expense of said corporation, to subscribers to such plan under a  
1297 contract entitling such subscribers to the benefits provided therein.  
1298 When so determined by any such corporation, comprehensive health  
1299 care shall also include appliances, drugs, medicines, supplies and all  
1300 other health goods and services, including the services of physicians,  
1301 doctors of dentistry and other licensed practitioners of the healing arts.  
1302 Any such corporation which provides coverage for the services of  
1303 physicians shall also provide coverage for the services of chiropractors  
1304 licensed under chapter 372 and naturopaths licensed under chapter  
1305 373. Each such corporation shall, except as [specifically designated  
1306 herein] otherwise provided in this title, be exempt from the provisions

1307 of the general statutes relating to insurance. The provisions of sections  
1308 38a-815 to 38a-819, inclusive, except subdivision (9) of section 38a-816,  
1309 shall be applicable to such corporation. Such hospitals, clinics and  
1310 chronic and convalescent nursing homes as shall be contained in a list  
1311 of approved institutions maintained by the Department of Public  
1312 Health shall be deemed approved for the purposes of sections 38a-214  
1313 to 38a-225, inclusive.

1314 Sec. 67. Subsection (b) of section 38a-480 of the general statutes is  
1315 repealed and the following is substituted in lieu thereof (*Effective*  
1316 *October 1, 2015*):

1317 (b) [The] Except as otherwise provided in this title, the provisions of  
1318 sections 38a-481 to 38a-488, inclusive, as amended by this act, 38a-492,  
1319 38a-502 and 38a-505 shall not apply to any subscriber contract issued  
1320 by a health care center.

1321 Sec. 68. Section 38a-512 of the general statutes is repealed and the  
1322 following is substituted in lieu thereof (*Effective October 1, 2015*):

1323 Any policy providing major medical expense coverage [which] that  
1324 is written to complement underlying hospital, medical and surgical  
1325 expense coverage [, unless otherwise specifically provided,] shall not  
1326 be required, unless otherwise specifically provided, to include the  
1327 benefits required in the underlying hospital, medical and surgical  
1328 expense coverage. [The] Except as otherwise provided in this title, the  
1329 provisions of sections 38a-513, as amended by this act, 38a-529, 38a-  
1330 532, 38a-545 and 38a-547 shall not apply to any subscriber contract  
1331 issued by a health care center.

1332 Sec. 69. Section 38a-336 of the general statutes, as amended by  
1333 section 1 of public act 14-20, is repealed and the following is  
1334 substituted in lieu thereof (*Effective October 1, 2015*):

1335 (a) (1) (A) Each automobile liability insurance policy shall provide  
1336 insurance, herein called uninsured and underinsured motorist

1337 coverage, in accordance with the regulations adopted pursuant to  
1338 section 38a-334, with limits for bodily injury or death not less than  
1339 those specified in subsection (a) of section 14-112, for the protection of  
1340 persons insured thereunder who are legally entitled to recover  
1341 damages because of bodily injury, including death resulting therefrom,  
1342 from owners or operators of uninsured motor vehicles and  
1343 underinsured motor vehicles and insured motor vehicles, the insurer  
1344 of which becomes insolvent prior to payment of such damages. [,  
1345 because of bodily injury, including death resulting therefrom.]

1346 (B) Each insurer licensed to write automobile liability insurance in  
1347 this state shall provide uninsured and underinsured [motorists]  
1348 motorist coverage with limits requested by any named insured upon  
1349 payment of the appropriate premium, provided each such insurer shall  
1350 offer such coverage with limits that are twice the limits of the bodily  
1351 injury coverage of the policy issued to the named insured. The  
1352 insured's selection of uninsured and underinsured motorist coverage  
1353 shall apply to all subsequent renewals of coverage and to all policies or  
1354 endorsements [which] that extend, change, supersede or replace an  
1355 existing policy issued to the named insured, unless changed in writing  
1356 by any named insured.

1357 (C) No insurer shall be required to provide uninsured and  
1358 underinsured motorist coverage to [(A)] (i) a named insured or  
1359 relatives residing in [his] the named insured's household when  
1360 occupying, or struck as a pedestrian by, an uninsured or underinsured  
1361 motor vehicle or a motorcycle that is owned by the named insured,  
1362 except as provided in subparagraph (D) of this subdivision, or [(B)] (ii)  
1363 any insured occupying an uninsured or underinsured motor vehicle or  
1364 motorcycle that is owned by such insured.

1365 (D) For each automobile liability insurance policy issued or renewed  
1366 on or after October 1, 2014, an insurer shall not deny uninsured  
1367 motorist coverage to a named insured or any relative residing in the  
1368 named insured's household solely on the basis that the named insured

1369 or such relative was struck as a pedestrian by a motor vehicle or  
1370 motorcycle, during the theft of such motor vehicle or motorcycle, that  
1371 is owned by the named insured and listed as a covered motor vehicle  
1372 on the named insured's policy.

1373 (2) Notwithstanding any provision of this section, each automobile  
1374 liability insurance policy issued or renewed on and after January 1,  
1375 1994, shall provide uninsured and underinsured motorist coverage  
1376 with limits for bodily injury and death equal to those purchased to  
1377 protect against loss resulting from the liability imposed by law unless  
1378 any named insured requests in writing a lesser amount, but not less  
1379 than the limits specified in subsection (a) of section 14-112. Such  
1380 written request shall apply to all subsequent renewals of coverage and  
1381 to all policies or endorsements that extend, change, supersede or  
1382 replace an existing policy issued to the named insured, unless changed  
1383 in writing by any named insured. No such written request for a lesser  
1384 amount shall be effective unless any named insured has signed an  
1385 informed consent form that shall contain: (A) An explanation of  
1386 uninsured and underinsured motorist insurance approved by the  
1387 commissioner; (B) a list of uninsured and underinsured motorist  
1388 coverage options available from the insurer; and (C) the premium cost  
1389 for each of the coverage options available from the insurer. Such  
1390 informed consent form shall contain a heading in twelve-point type  
1391 and shall state: "WHEN YOU SIGN THIS FORM, YOU ARE  
1392 CHOOSING A REDUCED PREMIUM, BUT YOU ARE ALSO  
1393 CHOOSING NOT TO PURCHASE CERTAIN VALUABLE  
1394 COVERAGE WHICH PROTECTS YOU AND YOUR FAMILY. IF YOU  
1395 ARE UNCERTAIN ABOUT HOW THIS DECISION WILL AFFECT  
1396 YOU, YOU SHOULD GET ADVICE FROM YOUR INSURANCE  
1397 AGENT OR ANOTHER QUALIFIED ADVISER."

1398 (b) An insurance company shall be obligated to make payment to its  
1399 insured up to the limits of the policy's uninsured and underinsured  
1400 motorist coverage after the limits of liability under all bodily injury  
1401 liability bonds or insurance policies applicable at the time of the

1402 accident have been exhausted by payment of judgments or settlements,  
1403 but in no event shall the total amount of recovery from all policies,  
1404 including any amount recovered under the insured's uninsured and  
1405 underinsured motorist coverage, exceed the limits of the insured's  
1406 uninsured and underinsured motorist coverage. In no event shall there  
1407 be any reduction of uninsured or underinsured motorist coverage  
1408 limits or benefits payable (1) for amounts received by the insured for  
1409 Social Security disability benefits paid or payable pursuant to the  
1410 Social Security Act, 42 USC Section 301, et seq., or (2) with respect to an  
1411 automobile liability insurance policy issued or renewed on or after  
1412 October 1, 2015, (A) for amounts paid by or on behalf of any tortfeasor  
1413 for bodily injury to anyone other than individuals insured under the  
1414 policy against which the claim is made, or (B) for amounts paid by or  
1415 on behalf of any tortfeasor for property damage. The limitation on the  
1416 total amount of recovery from all policies shall not apply to  
1417 underinsured motorist conversion coverage purchased pursuant to  
1418 section 38a-336a.

1419 (c) Each automobile liability insurance policy issued on or after  
1420 October 1, 1971, [which] that contains a provision for binding  
1421 arbitration shall include a provision for final determination of  
1422 insurance coverage in such arbitration proceeding. With respect to any  
1423 claim submitted to arbitration on or after October 1, 1983, the  
1424 arbitration proceeding shall be conducted by a single arbitrator if the  
1425 amount in demand is forty thousand dollars or less or by a panel of  
1426 three arbitrators if the amount in demand is more than forty thousand  
1427 dollars.

1428 (d) Regardless of the number of policies issued, vehicles or  
1429 premiums shown on a policy, premiums paid, persons covered,  
1430 vehicles involved in an accident, or claims made, in no event shall the  
1431 limit of liability for uninsured and underinsured motorist coverage  
1432 applicable to two or more motor vehicles covered under the same or  
1433 separate policies be added together to determine the limit of liability  
1434 for such coverage available to an injured person or persons for any one

1435 accident. If a person insured for uninsured and underinsured motorist  
1436 coverage is an occupant of a nonowned vehicle covered by a policy  
1437 also providing uninsured and underinsured motorist coverage, the  
1438 coverage of the occupied vehicle shall be primary and any coverage for  
1439 which such person is a named insured shall be secondary. All other  
1440 applicable policies shall be excess. The total amount of uninsured and  
1441 underinsured motorist coverage recoverable is limited to the highest  
1442 amount recoverable under the primary policy, the secondary policy or  
1443 any one of the excess policies. The amount paid under the excess  
1444 policies shall be apportioned in accordance with the proportion that  
1445 the limits of each excess policy bear to the total limits of the excess  
1446 policies. If any person insured for uninsured and underinsured  
1447 motorist coverage is an occupant of an owned vehicle, the uninsured  
1448 and underinsured motorist coverage afforded by the policy covering  
1449 the vehicle occupied at the time of the accident shall be the only  
1450 uninsured and underinsured motorist coverage available.

1451 (e) For the purposes of this section, an "underinsured motor vehicle"  
1452 means a motor vehicle with respect to which the sum of the limits of  
1453 liability under all bodily injury liability bonds and insurance policies  
1454 applicable at the time of the accident is less than the applicable limits  
1455 of liability under the uninsured motorist portion of the policy against  
1456 which claim is made under subsection (b) of this section.

1457 (f) Notwithstanding subsection (a) of section 31-284, an employee of  
1458 a named insured injured while occupying a covered motor vehicle in  
1459 the course of employment shall be covered by such insured's otherwise  
1460 applicable uninsured and underinsured motorist coverage.

1461 (g) (1) No insurance company doing business in this state may limit  
1462 the time within which any suit may be brought against it or any  
1463 demand for arbitration on a claim may be made on the uninsured or  
1464 underinsured motorist provisions of an automobile liability insurance  
1465 policy to a period of less than three years from the date of accident,  
1466 provided, in the case of an underinsured motorist claim the insured

1467 may toll any applicable limitation period (A) by notifying such insurer  
1468 prior to the expiration of the applicable limitation period, in writing, of  
1469 any claim which the insured may have for underinsured motorist  
1470 benefits and (B) by commencing suit or demanding arbitration under  
1471 the terms of the policy not more than one hundred eighty days from  
1472 the date of exhaustion of the limits of liability under all automobile  
1473 bodily injury liability bonds or automobile insurance policies  
1474 applicable at the time of the accident by settlements or final judgments  
1475 after any appeals.

1476 (2) Notwithstanding the provisions of subdivision (1) of this  
1477 subsection, in the case of an uninsured motorist claim, if the motor  
1478 vehicle of a tortfeasor is an uninsured motor vehicle because the  
1479 automobile liability insurance company of such tortfeasor becomes  
1480 insolvent or denies coverage, no insurance company doing business in  
1481 this state may limit the time within which any suit may be brought  
1482 against it or any demand for arbitration on a claim may be made on  
1483 the uninsured motorist provisions of an automobile liability insurance  
1484 policy to a period of less than one year from the date of receipt by the  
1485 insured of written notice of such insolvency of, or denial of coverage  
1486 by, such automobile liability insurance company.

1487 Sec. 70. Subsection (c) of section 38a-354a of the general statutes is  
1488 repealed and the following is substituted in lieu thereof (*Effective*  
1489 *October 1, 2015*):

1490 (c) [(1)] If there is any communication between a glass claims  
1491 representative for an insurance company doing business in this state or  
1492 a third-party claims administrator for such company and an insured  
1493 regarding automotive glass work or automobile glass products, in the  
1494 initial contact with the insured, such representative or claims  
1495 administrator shall state or disclose to the insured a statement  
1496 substantially similar to the following: "You have the right to choose a  
1497 licensed glass shop where the damage to your motor vehicle will be  
1498 repaired. If you have a preference, please let us know."

1499 [(2) No glass claims representative for an insurance company doing  
 1500 business in this state or a third-party claims administrator for such  
 1501 company shall provide an insured with the name of, schedule an  
 1502 appointment for an insured with or direct an insured to, a licensed  
 1503 glass shop that is owned by (A) such company, (B) such claims  
 1504 administrator, or (C) the same parent company as such insurance  
 1505 company or claims administrator, unless such representative or claims  
 1506 administrator provides the insured with the name of at least one  
 1507 additional licensed glass shop in the area where the automotive glass  
 1508 work is to be performed.]

1509 Sec. 71. Section 38a-513a of the general statutes is repealed. (*Effective*  
 1510 *October 1, 2015*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2015</i>	38a-470(b)
Sec. 2	<i>October 1, 2015</i>	38a-470(e)
Sec. 3	<i>October 1, 2015</i>	38a-478(5)
Sec. 4	<i>October 1, 2015</i>	38a-489
Sec. 5	<i>October 1, 2015</i>	38a-495a(a)(5)
Sec. 6	<i>October 1, 2015</i>	38a-498(b)(3)
Sec. 7	<i>October 1, 2015</i>	38a-503e(b)
Sec. 8	<i>October 1, 2015</i>	38a-503e(e)
Sec. 9	<i>October 1, 2015</i>	38a-506
Sec. 10	<i>October 1, 2015</i>	38a-508(c) and (d)
Sec. 11	<i>October 1, 2015</i>	38a-509(c)
Sec. 12	<i>October 1, 2015</i>	38a-513e(a)
Sec. 13	<i>October 1, 2015</i>	38a-515
Sec. 14	<i>October 1, 2015</i>	38a-523(b)
Sec. 15	<i>October 1, 2015</i>	38a-525(b)(3)
Sec. 16	<i>October 1, 2015</i>	38a-530e(b)
Sec. 17	<i>October 1, 2015</i>	38a-530e(e)
Sec. 18	<i>October 1, 2015</i>	38a-536(c)
Sec. 19	<i>October 1, 2015</i>	38a-537
Sec. 20	<i>October 1, 2015</i>	38a-548
Sec. 21	<i>October 1, 2015</i>	38a-549(c) and (d)

Sec. 22	<i>October 1, 2015</i>	38a-564(5)
Sec. 23	<i>October 1, 2015</i>	38a-577(b)
Sec. 24	<i>October 1, 2015</i>	38a-1040(2)
Sec. 25	<i>October 1, 2015</i>	18-52a
Sec. 26	<i>October 1, 2015</i>	20-7f(a)(4)
Sec. 27	<i>October 1, 2015</i>	8-265ss(d)
Sec. 28	<i>October 1, 2015</i>	14-36m(a)(3)
Sec. 29	<i>October 1, 2015</i>	36a-719h
Sec. 30	<i>October 1, 2015</i>	36a-760d(1)
Sec. 31	<i>October 1, 2015</i>	38a-12(b)
Sec. 32	<i>October 1, 2015</i>	38a-58g(b)(1)
Sec. 33	<i>October 1, 2015</i>	38a-69
Sec. 34	<i>October 1, 2015</i>	38a-156a(g)(5)
Sec. 35	<i>October 1, 2015</i>	38a-156e(a)(2)
Sec. 36	<i>October 1, 2015</i>	38a-261
Sec. 37	<i>October 1, 2015</i>	38a-297(d)
Sec. 38	<i>October 1, 2015</i>	38a-298(a)(4)
Sec. 39	<i>October 1, 2015</i>	38a-307a
Sec. 40	<i>October 1, 2015</i>	38a-322a(f)
Sec. 41	<i>October 1, 2015</i>	38a-330
Sec. 42	<i>October 1, 2015</i>	38a-338
Sec. 43	<i>October 1, 2015</i>	38a-472(c)
Sec. 44	<i>October 1, 2015</i>	38a-472a
Sec. 45	<i>October 1, 2015</i>	38a-478c(a)(1)
Sec. 46	<i>October 1, 2015</i>	38a-478c(a)(4)
Sec. 47	<i>October 1, 2015</i>	38a-478g(b)(14)
Sec. 48	<i>October 1, 2015</i>	38a-478l(c)
Sec. 49	<i>October 1, 2015</i>	38a-478r(c)
Sec. 50	<i>October 1, 2015</i>	38a-481(a) to (c)
Sec. 51	<i>October 1, 2015</i>	38a-513(a) and (b)
Sec. 52	<i>October 1, 2015</i>	38a-503c
Sec. 53	<i>October 1, 2015</i>	38a-530c
Sec. 54	<i>October 1, 2015</i>	38a-591d(e)(1)(H)
Sec. 55	<i>October 1, 2015</i>	38a-663
Sec. 56	<i>October 1, 2015</i>	38a-740
Sec. 57	<i>October 1, 2015</i>	38a-742
Sec. 58	<i>October 1, 2015</i>	38a-940(b)
Sec. 59	<i>October 1, 2015</i>	38a-1051(a)
Sec. 60	<i>October 1, 2015</i>	38a-1080

Sec. 61	October 1, 2015	38a-1081(c)(3) and (4)
Sec. 62	October 1, 2015	38a-1091(b)(3)(B)
Sec. 63	October 1, 2015	38a-1092
Sec. 64	October 1, 2015	52-549n
Sec. 65	October 1, 2015	38a-199(a)
Sec. 66	October 1, 2015	38a-214(a)
Sec. 67	October 1, 2015	38a-480(b)
Sec. 68	October 1, 2015	38a-512
Sec. 69	October 1, 2015	38a-336
Sec. 70	October 1, 2015	38a-354a(c)
Sec. 71	October 1, 2015	Repealer section

**Statement of Purpose:**

To make technical, conforming and minor changes to the insurance and related statutes.

*[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]*