

Legislative History for Connecticut Act

HB 6527	PA 95	1997
Senate - 2377-2385, 2469-2471		(12)
HOUSE: 2312-2328		(17)
INSURANCE: 15, 17, 21, 25, 27, 30-31, 34-35, 37, 39-40, 62-63, 66-67, 103-113, 125, 126-127, 130-131, 140-141, 170, 179, 181, 182, 183, 188, 190, 199, 200, 229-237		(52) 81p.

Transcripts from the Joint Standing Committee Public Hearing(s) and/or Senate and House of Representatives Proceedings

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GEN. ASSEMBLY  
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Senate

Wednesday, May 21, 1997

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Will you remark further? Will you remark further?

Senator LeBeau.

SEN. LEBEAU:

Thank you Madam President. If there's no objection, I'd like to move this to the Consent Calendar.

THE CHAIR:

Motion is to refer this item to the Consent Calendar. Without objection, so ordered.

THE CLERK:

Calendar 464, Files 458 and 723, Substitute for HB6527. AN ACT CONCERNING GENETIC INFORMATION AND INSURANCE COVERAGE. As amended by House Amendment Schedule A, which is LCO-8729. Favorable Report of the Committees on Insurance, Judiciary, and Public Health. Clerk is in possession of one Amendment.

THE CHAIR:

Senator Bozek.

SEN. BOZEK:

Thank you Madam President. I move acceptance of the Joint Committee's Favorable Report and passage of the bill, in concurrence.

THE CHAIR:

Question is on passage of the bill in concurrence with the House. Senator Bozek.

SEN. BOZEK:

Should the, we have an Amendment, do we have an LCO on that? Can we just stand at ease one second please.

SEN. JEPSEN:

Madam President, may I ask this. Oh, no we're all set.

THE CHAIR:

Senator Bozek actually has the floor. Senator Bozek.

SEN. BOZEK:

Madam President, there's an Amendment. I'd like to yield to Senator Williams for the Amendment, LCO-4864.

THE CHAIR:

Senator Williams, do you accept the yield?

SEN. WILLIAMS:

Yes, Madam President. Thank you, I withdraw any Amendments in my name.

THE CHAIR:

Thank you sir.

SEN. BOZEK:

Alright, Madam, thank you.

THE CHAIR:

Senator Bozek.

SEN. BOZEK:

Madam President, this bill makes it an unfair insurance trade practice on medical health coverage and using incorrectly genetic information on persons in medical health care decisions.

This bill also is, makes it illegal to refuse to insure, or continue to insure, or to limit the amount of extent of kind of coverage, or charge a different rate for the same coverage because of the genetic difference that might be made aware of to an insurance company for medical coverage.

There's a, Madam President, a representative from Blue Cross Blue Shield, representative at our public hearing spoke in support of it, Dr. David Park spoke in favor of it. He's the President of the Connecticut State Medical Society. And he did point out that this technology is important area to protect the public in.

And we did have a member, Riva Kinstlick, who's Vice President of Government Relations from Prudential Insurance Company, who spoke in favor, that is in support of the bill. And I believe that the, this bill here may not be complete for the year 2000, or 2001, but it's a necessary bill to protect the residents of the State of Connecticut with regard to the medical provider language that they may be subject to.

THE CHAIR:

Thank you sir.

SEN. BOZEK:

I move its passage and adoption, thank you.

THE CHAIR:

Question is on passage. Will you remark further on the bill? Senator Prague.

SEN. PRAGUE:

Thank you Madam President. I rise to support this bill and hope that my colleagues in this Chamber will do the same. Genetic testing for individuals could really add years to their life. But if there is a possibility of being denied health insurance because the companies are going to use the results of genetic testing, then many people would not undergo that kind of new technique that could very well be very beneficial.

You know, it would be outrageous if an insurance company denied health insurance on the basis of genetic testing. I'm pleased to hear from Senator Bozek that there was some insurance companies at the hearing that support this legislation.

This is really an excellent piece of legislation. And I hope that it will be supported by all members of this Chamber. Thank you.

THE CHAIR:

Thank you Senator.

THE CHAIR:

Will you remark further on the bill? Senator Bozek. Senator, excuse me, Senator Smith.

SEN. SMITH:

Thank you Madam President. I rise in support of the bill, but I do have a question, through you to the proponent.

THE CHAIR:

Please proceed.

SEN. SMITH:

On line 388 through 391, the last sentences of the bill. It says, genetic information means information about genes, gene products, or inherited characteristics. I think I know what a gene is, and I think I know what inherited characteristics are. What are gene products?

THE CHAIR:

Senator Bozek, do you care to respond?

SEN. BOZEK:

One second, Madam President.

SEN. SMITH:

I was wondering if my children are gene products?

SEN. BOZEK:

Madam President, I can tell you that I don't know the definition of gene products. I'm only, but I would surmise that in the context here, it must be those areas probably derived from medical treatment that probably produce a side, I'm guessing. That may produce alternate, or alternative type of products in gene testing that are, would otherwise be not considered normally, but because we have so many different by products that some by product, or alternate product from gene testing might produce some other area of definition, and therefore they want to probably cover besides genes, all areas that are derived from gene testing, or medical tests, chemical tests. I'm not sure but, I'd only guess in that area. I don't recollect that that definition was in question before.

THE CHAIR:

Senator Smith.

SEN. SMITH:

Thank you Madam President. I don't know what it means either. I guess it seems like a good idea, and a decent bill. It just concerns me that we're using terms that are undefined by the bill. Apparently undefined in law.

And none of us seem to have a particularly clear

idea what they mean, and yet we're outlawing their use. Like I said, I intend to vote for the bill, but it just doesn't strike me as very settling. I was wondering if the Senator had found something over there, I see him.

THE CHAIR:

Senator Smith, is that in the form of a question?

SEN. SMITH:

Did you find something, Senator?

SEN. BOZEK:

No, I did not Senator Smith.

THE CHAIR:

Senator Bozek.

SEN. BOZEK:

Madam President.

THE CHAIR:

Senator Bozek.

SEN. BOZEK:

Do I have the floor.

THE CHAIR:

You do now.

SEN. BOZEK:

Okay, thank you. Madam President, there has been a lot of language that we have read here and I believe that this falls in that category of non-descriptive, or for other reasons, alternative descriptive information

that is usually included in some of the, the desire to probably broadly cover areas that are of interest or concern, or with regard to any issue.

And in this particular case, if gene products were left out, I'm sure that it probably may not make any difference. It's probably two words combined to probably assist in the definition of gene, gene testing. However medically, and scientifically gene testing is accomplished, I'm sure that the products or by products are probably intended by this term to refer to those areas.

It doesn't seem over complex other than a broad term placed in the language describing what's allowed, and what's, in this case what's prohibited from an insurer being able to deny medical coverage, or charge different prices.

THE CHAIR:

Senator Smith.

SEN. SMITH:

Thank you Madam President. Well, with that thought, if anybody comes up with a definition, I'd be happy to know it. But other than that, it seems like a good bill. Thank you Madam President.

THE CHAIR:

Thank you sir. Will you remark further on the

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bill? Will you remark further? Senator Bozek.

SEN. BOZEK:

I think that was a very good point. Like I say, I think some of these in other forms exist in other bills. And I don't think it's something that takes away from the bill. If there's no other discussion, I'd move this be placed on the Consent Calendar.

THE CHAIR:

Motion is to refer this item to the Consent Calendar. Without objection, so ordered. At this time the Chair will entertain points of personal privilege or announcements. Senator Coleman.

SEN. COLEMAN:

Thank you Madam President. For purposes of an introduction.

THE CHAIR:

Please proceed.

SEN. COLEMAN:

Madam President, Franzina Halloway is a current legislative staff person, and has been a legislative staff person here for, on and off for over twenty years. She's also a resident of my district. And she's also the proud mother of Rand Washington, and the sometimes proud mother-in-law to Joe Washington, both of whom are present here in the Chamber.

Those Voting Yea	34
Those Voting Nay	0
Those absent and not voting	2

## THE CHAIR:

The bill as amended is passed. At this time would the Clerk please call the Consent Calendar.

## THE CLERK:

Madam President, the second Consent Calendar begins on Calendar Page 5. It's Calendar 316, Substitute for SB73.

Calendar Page 6, Calendar 375, Substitute for SB1168  
SB1186.

Calendar Page 9, Calendar 425, Substitute for  
SB857.

Calendar Page 12, Calendar 451, Substitute for  
HB5513.

Calendar 452, HB6894.

Calendar 453, HB5471.

Calendar Page 14, Calendar 462, Substitute for  
HB5646.

Calendar 463, HB6748.

Calendar 464, Substitute for HB6527.

Calendar Page 18, Calendar 485, Substitute for  
HB6705.

Calendar 489, Substitute for HB5559.

Calendar Page 23, Calendar 166, SB1187.

Calendar Page 26, Calendar 258, SB503.

Calendar Page 27, Calendar 279, Substitute for  
SB1315.

Calendar Page 29, Calendar 315, Substitute for  
SB995.

Calendar Page 30, Calendar 325, Substitute for  
SB1122.

Calendar Page 31, Calendar 333, Substitute for  
SB1254.

Calendar 364, Substitute for HB6658.

Calendar 424, Substitute for SB575.

Calendar Page 32, Calendar 190, Substitute for  
SB1224.

Calendar 222, Substitute for SB1024.

Calendar Page 33, Calendar 369, Substitute for  
HB5042.

Madam President, that completes the second Consent  
Calendar.

THE CHAIR:

Thank you Mr. Clerk. Would you please announce a  
roll call vote on the Consent Calendar. The machine  
will be open.

THE CLERK:

Immediate roll call has been ordered in the Senate

on the second Consent Calendar. Will all Senators please return to the Chamber. An immediate roll call has been ordered in the Senate on the second Consent Calendar. Will all Senators please return to the Chamber.

THE CHAIR:

Have all members voted? If all members have voted, the machine will be locked. Clerk please take a tally.

THE CLERK:

Motion is on the adoption of the second Consent Calendar.

Total Number Voting	35
Those Voting Yea	35
Those Voting Nay	0
Those absent and not voting	1

THE CHAIR:

Consent Calendar is adopted. At this time with the passage of the Consent Calendar, at Disagreeing Actions on Page 33, Calendar 369, at this time will be the prerogative of the Chair to appoint the Conference Committee.

And on that Conference Committee will serve Senator Handley, Senator Harp, Senator Nielsen. And I ask the members to meet to conduct the business of the

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Representative Mantilla will be recorded in the affirmative, anybody else? Clerk please announce the tally.

CLERK:

Senate Bill 1223 in concurrence with the Senate.

Total Number Voting	119
Necessary for Passage	60
Those voting Yea	115
Those voting Nay	4
Those absent and not voting	32

SPEAKER RITTER:

Bill passes. Clerk please call Calendar 362.

CLERK:

On page thirty-one, Calendar 362, substitute for  
HB6527. AN ACT CONCERNING GENETIC INFORMATION AND  
INSURANCE COVERAGE. Favorable report of the Committee  
on Public Health.

SPEAKER RITTER:

The Honorable Representative from the 87th  
district Representative Fontana you have the floor sir.  
REP. FONTANA: (87th)

Thank you Mr. Speaker. Mr. Speaker I move for the  
acceptance of the Joint Committee's favorable report  
and passage of the bill.

SPEAKER RITTER:

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Motion is on acceptance and passage, please proceed sir.

REP. FONTANA: (87th)

Thank you Mr. Speaker. Mr. Speaker, this bill makes it an unfair and deceptive insurance practice for medical coverage providers that offer individual or group health insurance coverage to: 1) to refuse to insure or to continue to insure, 2) limit the amount, extent or kind of coverage, or 3) charge a different rate for the same coverage on the basis of an individual's genetic information.

The bill also prohibits medical coverage providers from using a person's genetic information to form the basis of a pre-existing condition without a medical diagnosis based on medical information other than genetic information and symptoms of a disease or condition.

Mr. Speaker I would also now like to yield to Representative Scalettar.

SPEAKER RITTER:

Representative Scalettar will you accept the yield madam?

REP. SCALETTAR: (114th)

Yes, thank you Mr. Speaker. Mr. Speaker, as the knowledge about the genetic basis of many disorders

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increases we also see an increased potential for misuse of that information. Certainly discrimination in health insurance is one of the greatest potential misuses that there can be.

Although we have not had any examples, fortunately, in Connecticut there are examples around the country of people being denied insurance because of genetic pre-disposition to disease. The consequences of being denied insurance, particularly health insurance, are obvious. But in addition to the actual denial of the insurance merely the fear that discrimination exists can be of tremendous concern.

Mr. Speaker it may discourage participation in research and it may keep people from seeking the preventive and treatment options that would be helpful to them. As we deal with the problem it is particularly important that we have a very broad definition of genetic information so that it is that information that cannot be used in discriminating with respect to health insurance.

Genetic information can come from DNA or RNA testing. It can be inferred by measuring gene products which are proteins from other genetic information. Signs on physical examination or X-ray examination can indicate genetic problems. And also, and very

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importantly, genetic information can come from family history. It can come from diseases that relatives have or genetic tests that relatives have taken. And it is very important to know that the broad definition in this bill does include family history. Mr. Speaker, the Clerk has LCO 8729, will he call and I be permitted summarize?

SPEAKER RITTER:

Clerk does have LCO 8729, which I'll designate as House "A." If he may call and Representative Scalettar would like to summarize.

CLERK:

LCO 8729, House "A" offered by Representative Scalettar.

SPEAKER RITTER:

Representative Scalettar.

REP. Scalettar: (114th)

Thank you Mr. Speaker. Mr. Speaker, this amendment simply clarifies that where there is the actual existence of disease which has been diagnosed without the use of genetic information the fact that someone also has a genetic test will not preclude an insurer from refusing to insure or applying a pre-existing condition limitation which currently exists under the law.

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It's a very specific situation Mr. Speaker, and does not affect the general prohibition against using genetic information in the denial of insurance, I move adoption Mr. Speaker.

SPEAKER RITTER:

Question on adoption of House "A" will you remark further? Will you remark further? Representative Belden from the 113th.

REP. BELDEN: (113th)

Thank you Mr. Speaker. Mr. Speaker it has been very difficult to hear the lady bring out the amendment and understand what it was all about.

SPEAKER RITTER:

One second then Representative Belden. You know I try to have fine line here, of having people conduct their business on the floor and trying to debate. Representative Belden is trying have some discourse with Representative Scalettar, I would ask all staff members please leave the floor and try to have our members have your discussions either in the far back or outside. We'll stand at ease for a moment. Would you like Representative Scalettar to do her summarization again sir?

REP. BELDEN: (113th)

Perhaps if I can just ask her a question.

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SPEAKER RITTER:

You have the floor sir.

REP. BELDEN: (113th)

Thank you Mr. Speaker. Through you Mr. Speaker, having just received the amendment and not really having time to go through the entire file again, is this amendment just dealing with information or is it a significant change in the law which would put a mandate on insurance companies with regard to pre-existing conditions? Through you Mr. Speaker.

SPEAKER RITTER:

Representative Scalettar.

REP. SCALETTAR: (114th)

Thank you Mr. Speaker. This does not put any mandate on insurance companies. It was, it's actually at the request of certain insurers. What happens now is that, although it generally in group insurance we do not have the individually underwritten policies, there still are some group insurers who do provide individual insurance and individually underwrite for it.

This is just to make clear that in this circumstance, where someone has been diagnosed with an actual disease, and the diagnosis is based on other medical information other than genetic information and the person has exhibited symptoms of the disease, the

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fact that, that person also has taken a genetic test will not preclude the insurer from exercising the rights it currently has under the law, either to implement a pre-existing condition exclusion or some other exclusion that currently exists under the law. There is absolutely no mandate on insurers here. Through you Mr. Speaker.

REP. BELDEN: (113th)

Thank you Mr. Speaker.

SPEAKER RITTER:

Thank you sir. Will you remark further on House Amendment "A"? If not I'll try your minds. All in favor signify by saying aye.

REPRESENTATIVES:

Aye.

SPEAKER RITTER:

Opposed no? House "A" is adopted will you remark further on this bill as amended by House "A"?

Representative Veltri of the 9th.

REP. VELTRI: (9th)

Thank you Mr. Speaker. To the maker of the bill itself, like the main bill, if I could ask a question.

SPEAKER RITTER:

Please proceed sir.

REP. VELTRI: (9th)

The bill talks about passing on the genetic information, not being able to be used by insurance companies. Do we have laws on the books to prevent the people to generate the genetic information from keeping it confidential? So that they can't get out?

SPEAKER RITTER:

Representative Fontana.

REP. FONTANA: (87th)

Through you Mr. Speaker, I'm not quite sure I understand. Do you mean the research facilities or the testing facilities that test individuals?

REP. VELTRI: (9th)

Yes. Are they obligated to keep that confidential at the test point? Rather than release the names of the results of genetic testing? Because if they aren't then why are we making this part of the bill?

REP. FONTANA: (87th)

Through you Mr. Speaker, I would say yes because it adheres to the current physician patient privilege.

REP. VELTRI: (9th)

Well Mr. Speaker, I'm not sure, are all genetic tests done under a physician or are they done in research laboratories where you don't have the confidentiality of physician knowledge?

REP. FONTANA: (87th)

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Through you Mr. Speaker, I believe it's done through or under the supervision of a physician.

REP. VELTRI: (9th)

Alright. Thank you.

REP. FONTANA: (87th)

Thank you.

SPEAKER RITTER:

Will you remark further? Representative Farr of the 19th.

REP. FARR: (19th)

Thank you Mr. Speaker. I just wanted to emphasize, that in the testimony in the committee there was in fact no evidence given that there had ever been a case in Connecticut, and in fact nobody could given any instances where a carrier had discriminated in the United States. But the reason I think for the bill, and it was that the testimony before the committee was that individuals were afraid of doing genetic testing and they were afraid of that because of the general belief that somehow that result would be used against them to deny medical insurance.

So while I think that the bill is not going to, is not required to prevent insurance companies from discriminating against people, because I don't believe they're doing that. But I do think it's important

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because it will result in the public understanding that they can't do it and therefore they can safely go ahead and get genetic testing.

It's similar to a situation we had years ago when most states passed good Samaritan laws so that medical providers could safely aid at an accident. It turned out that no cases had ever been brought against medical providers, but medical providers being afraid of being sued were changing their conduct and were reluctant in giving that emergency aid.

So I think this will change the conduct of people and make them assured that there will be no negative consequences. That this is a medical decision they ought to be making whether they do the testing or not and I would urge passage of the bill. Thank you.

SPEAKER RITTER:

Thank you sir. Representative Dandrow from the 30th.

REP. DANDROW: (30th)

Thank you Mr. Speaker. I would like to say this past session I co-chaired the Huntington's Disease Task Force which is certainly a genetic disease that is passed on and on for generations. I can tell you that there was real fear among the many members that we heard from at the public hearings and that sent back

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letters sent back to us to have some aid for these people and they were very fearful of insurance and employer information. I really urge the passage of this bill certainly on behalf of them. Thank you.

SPEAKER RITTER:

Thank you very much madam. Anybody else? If not, staff and guests please come to the well of the house the machine will be open.

CLERK:

The House of Representatives is voting by roll call, members to the chamber. The House is voting by roll call, members to the chamber please.

SPEAKER RITTER:

Have all the members voted? Please check the roll call machine to make sure your vote is properly cast. As soon as the Chairman of the Human Services Committee votes the machine will be locked. Clerk please take the tally. Will the Clerk please announce the tally.

CLERK:

Souse Bill 6527 as amended by House "A."

Total Number Voting	126
Necessary for Passage	64
Those voting Yea	126
Those voting Nay	0
Those absent and not voting	25

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SPEAKER RITTER:

Bill as amended passes. Clerk please call  
Calendar 459.

CLERK:

Page seventeen, Calendar 459, SB858. AN ACT  
CONCERNING BOATING. Favorable report of the Committee  
on Government Administration and Elections.

SPEAKER RITTER:

Representative Stratton.

REP. STRATTON: (17th)

Thank you Mr. Speaker. I move acceptance of the  
Joint Committee's favorable report and passage of the  
bill in concurrence with the Senate.

SPEAKER RITTER:

Motion on acceptance and passage in concurrence  
with the Senate, please proceed madam.

REP. STRATTON: (17th)

Thank you Mr. Speaker. This bill authorizes or  
directs the Department of Environmental Protection to  
investigate serious boating accidents. It provides for  
a reciprocity agreement for jet-ski operators from  
other states who have passed similar certification  
courses and it authorizes the department to issue  
permits for marine events on federal waters that the  
Coast Guard no longer deals with. I think it's

important to just note that while this bill extends the authority of DEP to investigate serious boating accidents that nothing in the underlying bill prevents local police departments from conducting their own concurrent investigations if those accidents occurred on waterways within their jurisdiction. And I would urge adoption of the bill.

SPEAKER RITTER:

Thank you very much madam, will you remark further on this bill? Representative Simmons from the 43rd.

REP. SIMMONS: (43rd)

Thank you Mr. Speaker. Through you a question to the proponent of the bill?

SPEAKER RITTER:

Please proceed.

REP. SIMMONS: (43rd)

Thank you Mr. Speaker. One of the provisions of the bill regards regatta permits and reduces, or increases the time from 15 to 30 days that an entity must file for a regatta. Could I ask the proponent of the bill why that change is taking place?

SPEAKER RITTER:

Representative Stratton.

REP. STRATTON: (17th)

The underlying purpose for this and I assume the

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increased time for the department is in order to be able to deal with the requests. The waters that are being embraced in the bill that are not currently under DEP authority had been controlled by the Coast Guard events like the bass fishing tournament and things of that sort. And I think in order to provide the kind of notice and provisions to assure adequate staffing to cover what are relatively large events in those circumstances, the Department felt they needed that extra time for notification.

REP. SIMMONS: (43rd)

And could the lady share with me what constitutes a regatta for purposes of this section? Through you Mr. Speaker.

SPEAKER RITTER:

Representative Stratton.

REP. STRATTON: (17th)

Through you Mr. Speaker, without checking back into statutory definition my initial response would be, would be the same thing that is currently regulated by the department on waterways under their jurisdiction and that the definitional frame work would not differ between either category.

All that we're changing in this legislation is the waterway under which the DEP has the authority to issue

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those permits.

REP. SIMMONS: (43rd)

So would I be safe to assume that a regatta would be an organized sailing contest, pre-posted or pre-notified to, for example, to the Eastern Connecticut Sailing Association, or to U.S. Sail or to other entities which routinely submit information on these events to the Coast Guard, but under the provisions of this bill a regatta would not be an adhoc sailing race conducted let's say on a weekend by a group of people who wish to have a recreational event. Through you Mr. Speaker.

SPEAKER RITTER:

Representative Stratton.

REP. STRATTON: (17th)

Through you Mr. Speaker. For the purpose of legislative intent, I think the brief answer is yes, you can assume that, that would be the case.

REP. SIMMONS: (43rd)

Thank you madam, thank you Mr. Speaker.

SPEAKER RITTER:

Thank you sir. Anybody else? Representative Sauer from the 36th.

REP. SAUER: (36th)

I have a question through you Mr. Speaker to the

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proponent of the bill.

SPEAKER RITTER:

One second madam. If the Chamber could give a little order here. Please proceed madam.

REP. SAUER: (36th)

For the proponent of the bill through you Mr. Speaker.

SPEAKER RITTER:

Please frame your question.

REP. SAUER: (36th)

You stated that both the DEP and the emergency personnel can conduct their investigations. And I wondered in the case of an emergency, who has the primary responsibility. The reason I ask the question is that there was at least one incident of a serious accident where there was quite a bit of resentment and I just want to be sure, in the case of an emergency, who has the precedence? Through you Mr. Speaker.

SPEAKER RITTER:

Representative Stratton.

REP. STRATTON: (17th)

Through you Mr. Speaker, the first responsibility would obviously be I think who was first called. What the bill is saying is that if that first notification goes to the local emergency personnel that they must

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immediately also notify DEP. And one of the reasons for that, is often whoever is notified that actually DEP has staff or personnel in the area to respond in exactly the kind of circumstance you have been speaking about. This does not place the onus upon the person reporting the accident in the boat, it merely says that if the emergency personnel receive that notification they must also immediately notify DEP.

SPEAKER RITTER:

Representative Sauer, you still have the floor.

REP. SAUER: (36th)

Again through you Mr. Speaker, for the purpose of legislative intent. If both the emergency department and the DEP are at the scene who is in charge?

SPEAKER RITTER:

Representative Stratton.

REP. STRATTON: (17th)

Through you Mr. Speaker, I don't believe that the legislation address that circumstance. We have many, many situations in the state where numerous personnel would respond to an emergency situation and that usually is a collaborative effort to try to deal with that situation, what the legislation and I guess the answer to your questions through you Mr. Speaker, is that it's relatively silent on that specific issue.

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would be able to respond and take the action that it would not be the basis of the decision.

There is one other bill that I just want to comment on, if I may, quickly.

REP. AMANN: Commissioner, if you could wrap it up within the next 30 seconds.

COMM. REIDER: Surely. And that has to do with an act allowing health care centers to maintain more than one network and to permit variations in rates for small employers. I won't go beyond saying that we do have some concern and reservation in that arena and we'll provide that. And, finally, on all these matters including, which I didn't mention, the post maternity care, there is some drafting issues that we will be more than happy to work with the Department. I appreciate your time and at any point just call and we'll be available. Thank you.

REP. AMANN: Thank you, sir. The next speaker is Attorney General Richard Blumenthal followed by Leslie Brett.

ATTORNEY GENERAL RICHARD BLUMENTHAL: Thank you very much, Mr. Chairman and members of the Committee. I am here principally on behalf of SB 330. Before reaching that measure, which is an act concerning minimum stay for post maternity care. I want to comment, very briefly, on two other measures that are under consideration. First of all with respect to HB 5434, an Act Concerning Premium Discounts for Window Etching, I'd like to restate and reiterate my support for that measure which I backed last year, as you know. Window etching is an absolutely proven deterrent to auto theft, which has become more rampant and ever increasingly prevalent particularly in medium sized cities. As you well know we had an epidemic of it in large cities, like Bridgeport. There were regional task forces developed to combat it. Now more and more it's a problem that has spread to medium size cities which is the reason that this measure, with respect to window etching, is endorsed by the FBI, the Connecticut State Police, the AAA, and major insurance companies that have a real financial

women the choice, and I emphasize it is a choice, of staying longer than 24 hours, a minimum of 48 hour coverage for normal childbirth without problems. I know that a father is probably well advised to be somewhat humble and circumspect in talking about the physical and emotional task that follow childbirth, but my own experience as a parent four times at least gives me some passing acquaintance with the challenges that a new mother faces. And I want to emphasize that it's not only a first time mother, different babies are different and they have different problems. And mothers feel differently about births and about caring for newborns in light of the different difficulties that each experiences. And some of those difficulties may be, indeed, life threatening such as jaundice but not easily diagnosed during the first 24 hours.

So I'm urging that the Committee consider, very carefully, the support, overwhelming support of the medical community specifically, pediatricians and obstetricians who have advocated publicly that a minimum of 48 hours be covered so that they can advise their patients without the financial burdens impending or imposed on them by 24 hour coverage. That women be free to make those choices in consultation with their pediatricians or obstetricians. Not that they be required to stay for 48 hours but simply have the option and choice, for their sake and for all our sakes. Because those children or mothers who have to be readmitted for further treatment after conditions are not properly diagnosed, ultimately raise insurance premiums and hospital expenses for all of us.

And I want to add one point that I think is very important and that is that there should be, very clearly, both a private and public right of action against any company that fails to follow the law if this measure is indeed made law. Those kinds of sanctions ought to be not only the threat of a private or a public action, but also fines or penalties such as we now have under the Unfair Insurance Practices Act. And I would commend the Committee particularly, and I hope it will retain this provision, for including a prohibition against

confusion that has existed for many years over whom an agent is representing.

Because of misunderstandings which sellers, buyers, and agents have experienced in the laws of agency, law suits throughout the country have increased and often times innocent parties have become the victims. Much time has been devoted to this problem by both regulators and the industry representatives in Connecticut and it is their consensus that this proposal makes the most sense. And I would note that the Real Estate Commission in January voted unanimously to support this bill and I would like to thank the Connecticut Association of Realtors for all their work in studying this issue.

We would recommend an effective date of June 1, 1997 which differs from the proposed bill, so that it will allow for the necessary time to provide training for all of Connecticut's 20,000 licensees. It is our intent to revise the Department regulations to require a three hour education module on agency law to be completed during the next renewal period. In fact, we have already met with the UCONN Center for Real Estate and Urban Economic Studies to help us draft a course outline.

I wish to thank you for the opportunity to be heard and would be pleased to answer any questions you might have.

SEN. DeLUCA: Thank you, John. Just one quick question. When you said you would require a three hour component of, would that be of the twelve or in addition to the twelve?

JOHN FREY: It would be of the twelve.

SEN. DeLUCA: It would be of the twelve. So therefore you would be mandating of the twelve hours needed, real estate law --

JOHN FREY: Fair housing.

SEN. DeLUCA: Fair housing and this one, if it were to pass, mandatory nine of the twelve hours.

Representative Abrams.

REPRESENTATIVE ABRAMS: Thank you, Mr. Chairman. Mrs. Gaffey, on behalf of the Meriden block on this Committee we'd like to welcome you and Colleen.

KATHY GAFFEY: Thank you very much.

REP. ABRAMS: To the Capitol and to whoever that guy you're with is. Sometimes we get lost in abstract concepts and it does us some good sometimes to see that they come down to people as opposed to dollars and cents.

KATHY GAFFEY: And that's what it's all about.

REP. ABRAMS: And we appreciate you coming up today.

KATHY GAFFEY: Thank you.

REP. ABRAMS: And bringing the best known baby in Meriden, Connecticut up with you. Thanks a lot.

KATHY GAFFEY: Thanks, Jim.

SEN. DeLUCA: Further questions? Thank you -- excuse me, Senator. Senator Williams.

SENATOR DONALD WILLIAMS: Thank you, Mr. Chairman. I too would like to commend you for coming today and educating the Committee on this very important issue. And judging by your husband's manner in holding Colleen during your testimony, I'd like to commend you educating the Senator as well.

KATHY GAFFEY: Sometimes that's the hardest job I have.

SEN. DeLUCA: He apparently won't be proposing any legislation in that area. Thank you. Now we will close the elected officials and agency head portion and go into the public portion. As Representative Amann said earlier we would appreciate keeping your remarks to the minimum within the time frame of three minutes. I notice that a number of people are testifying on 330, which is the maternity bill, and we appreciate that. But I would remind you that we did have a hearing on January 16 before

mother and not by economic considerations of the insurance company.

By supporting this bill, we are not advocating legislation intervening into a physician's clinical decision making as Commissioner Reider alluded to a little while ago. Making laws in Hartford is not the ideal way to guide medical practice. But the realities of managed care require us to seek, from legislators, safeguards for the patients, the mothers and the newborns. It is the physician's duty to protect the mother and newborns and we need your help. Neither the doctor nor lawmakers can advocate this responsibility to organizations which motives are primarily financial.

In cases of uncomplicated birth, where the mother desires to go home, and the physician agrees it is safe, and appropriate follow up care is provided the patient can be discharged early and that has been shown. However, it is, if this is not the case the coverage should be available to accommodate the appropriate length of stay for each individual mother and newborn. This legislation, we are supporting, does not mandate a length of stay. It mandates coverage to be available for the 48 hour normal spontaneous delivery, 96 hours caesarian section following delivery, not the time of admission to the hospital.

Managed care companies will tell you that if it the physician, not the companies, who decide to discharge patients early. But what they won't tell you is that many of the practice guidelines direct physicians to discharge the mothers within 24 hours or less. And you just heard, Senator Gaffey's wife say she was admitted and had to be discharged at 6:00 p.m, 24 or 23 hours after her delivery. Some women are being discharged at 2:00 a.m, 3:00 a.m, and 4:00 a.m., which is ludicrous.

Some companies actually retaliate against physicians who come, who keep patients in beyond this 24 hour threshold by taking disciplinary action or dropping them for participating in plans altogether, a practice known as deselection. In many cases the physician is given absolutely no

a provision also restricting carriers from providing monetary or other incentives to new mothers and women from leaving the hospital in advance of the suggested minimum time frames.

Third, I wanted to comment on one of the things that the Attorney General pointed out. He said that all women should have the right to this coverage. In order to do that, you would need to cover women in self insured plans and uninsured women. I don't know how far the counterpart House bill from the Public Health Committee goes toward achieving that end, but it appears to me that putting the mandate on the institution or the hospital as well as the insurance company would get at this problem. I strongly urge you to consider that measure and adding that into your bill.

And finally, neither of the bills addresses a grievance procedure or an appeal's procedure. And while we can suspect that that might be part of some other managed care reform legislation that will be considered this session, I'd like to ask that it be included specifically in this bill because we're not sure what form that will take if it will take any at all. Thank you.

SEN. DeLUCA: Thank you. Questions, comments? Thank you for coming this morning. Next is Don Roll to be followed by Pete Wilson.

DON ROLL: Thank you, Senator DeLuca, Representative Amann, members of the Committee. My name is Don Roll. I'm the Director of Government Relations for Blue Cross. And I'm here to speak on SB 332, An Act Allowing Health Care Centers to Maintain More than One Network and to Permit Variations of Rates for Small Employers. I'll give you a very brief background on this. Last year at this time, Blue Cross had three affiliated HMO's, Blue Care Enterprise Health Plan, known as Blue Care, Constitution Health Care, and Community Health Care Plan. We are in the process of dissolving those three affiliates and turning them into lines of business of Blue Cross and Blue Shield of Connecticut.

(Gap in testimony changing from Tape 1A to Tape 1B.)

DON ROLL: Enterprise Health Plan and CHC have already been merged into Blue Cross. Constitution Health Care is pending, at this moment, an approval from the Insurance Department. A public hearing was held a couple of weeks ago on that request for CHCP. Our intention at the time that we were doing that was to save on administrative costs, etcetera, of running four separate corporations. We fully intended to actually maintain product lines that very closely mirrored the previous separate corporation plans. So we would have a Constitution Health Care policy within Blue Cross and Blue Shield of Connecticut. And a CHCP policy within Blue Cross and Blue Shield of Connecticut. And that the action would be seamless to the members and they would really not see any difference. The only hang up there would be with the CHCP plan where CHCP did have their own pharmacies within their health care centers and once they were no longer established under HMO they wouldn't have been allowed to have a pharmacy within the Center, so, that was owned by CHCP. But that would have been the only change that was visible, really, to the membership. They would have gone to the same doctors, same kinds of plans, etcetera.

The other thing that you should know is that Enterprise Health Plan was a directly contracting HMO. We directly contracted with providers of service. CHC contracted with the various independent practice associations around the state. So CHC would contract with the Hartford IPA, for example, and all of the doctors within the Hartford IPA then could provide service to CHC members. CHCP was a staff model HMO with employed physicians. So they were three different model of HMO with three very different networks although there was some overlap in all of them.

In setting this up, one of the problems that we encountered was that the Department of Insurance told us that they did not allow HMO's to have multiple networks within the same service area. I might point out there is nothing in the current

than the rate for those that could go to 5,000 doctors in the state whichever ones they wanted, etcetera.

REP. EBERLE: So if you had it in your mind, I don't want to participate in a plan that's captivated because I don't think captivation is good than I have a choice --

DON ROLL: Then you'd go to the other plan that isn't.

REP. EBERLE: Pay more money and go to the other one.

DON ROLL: Correct.

REP. EBERLE: Thank you.

SEN. DeLUCA: Further questions? Representative Nardello?

REP. NARDELLO: Hi Don. I was wondering, this bill, as I was reading it, seems to me to have a bearing on medicated managed care in your Blue Care plan. Is this part of why this bill rose? Can you give me a little background on this because it would be a different method of reimbursement and it would be a different set of providers.

DON ROLL: And a different network. I believe that I am correct, I know that I'm correct that at one time the Insurance Department had decided that the Medicaid Managed Care was a self insured arrangement rather than a fully insured arrangement. I don't know whether that's still their view, but it was their view some months ago. Therefore, it really wouldn't apply if that's correct, if it is a self insured arrangement. It is a problem for us as far as the multiple networks, certainly. And, again, -- well again the payment method as well. But that isn't a small group. So the small group law doesn't apply to the Medicaid Managed Care.

But if it's determined that Medicaid Managed Care is an insured line, then we clearly need the ability to have a different network because not all providers that are in our normal business want to

be in Medicaid and not all that are in Medicaid want to be in the normal private business market as well. Another place that this is coming to light, we're getting ready to file with the federal government for a Medicare risk contract, a Medicare HMO. Again, the provider base may be different in that because of who the providers want to see and who they don't want to see. Another reason that we feel that we need that ability at least to differentiate and have more than one network within the same service area. I don't believe the Department has a problem with that concept for a different network for Medicare and a deferent network for Medicaid than for private business. You simply cannot get all of the providers who are wiling to see private business willing to see Medicaid for the rates that we're allowed to reimburse them under what the states is reimbursing us.

REP. NARDELLO: Thank you very much.

SEN. DeLUCA: Further questions, comments? Thank you for coming.

DON ROLL: Thank you.

SEN. DeLUCA: Next is Pete Wilson. And I know I'm going to pronounce this other name improperly because it's blurred Mary Parente.

PETE WILSON: Thank you, Mr. Chairman. My name is Peter Wilson. I'm an insurance agent doing business in New Canaan. I am testifying today on behalf of the Professional Insurance Agents of Connecticut, Inc., of which I am currently serving as President Elect. PIACT is a trade organization representing a membership of more than 600 insurance agents who employ 3,600 people throughout the state. PIACT commends the motivation behind HB 3535 and supports HB 5434 the goal of the bill to combat theft and fraud. However, the current wording of the bill could result in artificially suppressed premiums which do not reflect actuarially appropriate premium reductions for window etching practices.

The current language of lines 22 to 27 of the bill

SEN. DeLUCA: Already do.

PETE WILSON: Already do. But once again, it's to the comprehensive coverage which is where theft is covered, not to the entire premium.

SEN. DeLUCA: Oh, I understand that and this is only what this would apply to also because it shouldn't apply to the total premium because it has nothing to do with liability. I would agree. So if it were to become more common place in Connecticut that people were doing window etching from a competitive basis companies might start to offer that additional discount that they do now for safety belts and all the other things that they do.

PETE WILSON: Right, yes.

SEN. DeLUCA: You think that's a possibility.

PETE WILSON: Yes.

SEN. DeLUCA: Thank you. Any further comments, questions, members of the Committee?  
Representative Eberle.

REP. EBERLE: Okay. I guess I'm wondering if I live in an area where auto theft is minimal and I assume my premiums already reflect that I live in a low loss area, what effect would this have on me?

PETE WILSON: It would serve to reduce your comprehensive premium if you etched them. We live in an area which is pretty, the theft rate is not that high but people are having their cars stolen all the time from the railroad parking lots. And to therefore they may be coming from another area but they're still be stolen. The same thing if you park in a mall in another area.

REP. EBERLE: Okay, thank you.

SEN. DeLUCA: Further questions? Thank you, sir.

PETE WILSON: Thank you.

SEN. DeLUCA: The next is Mary Parente to be followed by

market has created situations where brokerage firms inadvertently practice undisclosed dual agency because the law inputs the knowledge of one salesperson in a firm to all other salespeople in that firm.

This imputation of knowledge creates a situation where an entire firm and all of its salespeople become dual agents when a salesperson in the firm has shown a property as a subagent and another salesperson in the same firm represents a buyer who is now interested in the property. This creates confusion within the real estate brokerage firm in tracking what property salespeople have shown and in what agency capacity. And it creates confusion among the buying public due to the fact that the buyer may be told in the middle of a transaction that the buyer representative that they were working with has now become a dual agent because someone else in that firm has shown the same property as the subagent.

Further confusion is created because there is currently no means for the real estate licensee to definitely know when the licensee has obtained the consent of the buyer and the seller to a dual agency relationship. The bill seeks to alleviate this confusion by eliminating the blanket offer made to subagents through Multiple Listing Service systems and creating a safe harbor in the form of a dual agency consent agreement. If blanket offers of subagency cannot be made through Multiple Listing Systems the practical effect for consumers using such systems is that the listing broker will always be, will always represent the seller and the cooperating broker will always represent the buyer with one exception. And that exception is that if the buyer wishes to purchase a property which is listed with the same real estate brokerage firm with whom the buyer is working, in that event the real estate brokerage firm would be a disclosed dual agent and would have the ability to use the safe harbor created in the bill.

Sellers would also benefit in that they would no longer be vicariously liable for what a cooperating broker acting a subagent said or did because all

cooperating brokers would be representing the buyer. The bill therefore lessens the confusion which the current state of the law creates with real estate licensees, real estate brokerage firms, buyers and sellers and will allow the market to work in a smoother manner while at the same time meeting the buyer's demands for increased representation and decreasing the liability sellers currently have with the use of subagents.

The bill also deals with confidential information problems which is currently confronting real estate brokerage firms. As a matter of stand now, a real estate licensee is obligated to tell a current client anything which the real estate licensee learned while representing a previous client. This obviously creates tensions for real estate licensees in handling confidential information which the licensee learned in the course of a past relationship and does not meet with the expectations of a real estate licensee's client that confidential information provided to the licensee will remain confidential. The bill, therefore, seeks to remove the licensee's obligation to disclose confidential information obtained from a past client to a current client thus insuring that the confidential information given to a real estate licensee will always remain confidential.

I would ask that you make this bill effective for listing and buyer representation agreements entered into after June 1, 1997. I understand that the Real Estate Commission wishes to use this time to conduct training programs for licensees. Given the confusion which is in the marketplace I certainly support the Commission's desire to have such a training program.

EUGENE MARCONI: For the record, Senator, I'm the staff attorney for the Connecticut Association of Realtors. To the credit of the Department of Consumer Protection and the Real Estate Commission, they both recognized that there were problems in this area. And the proposal that is before you in the Raised Bill represents a lot of effort on behalf of both industry and regulators to try and

newborn to severe and life threatening cardiac abnormalities that sometimes --

REP. AMANN: Dr. DeFrancesco, if you could wrap it up, please?

DR. MARK DeFRANCESCO: Yes, certainly. These cases do not represent -- the fact that these cases just represent the minority of patients does not make a big difference, the fact is that we shouldn't play the odds and we shouldn't gamble with our patients. It should be acknowledged that when a complication occurs there is always the possibility that readmission and treatment might be too little, too late and the mother or baby's life may in fact be lost.

This bill will simply recommend, simply allow us to keep patients up to 48 hours and up to 96 hours for vaginal and caesarean sections respectfully if it is deemed appropriate medically by the patient and the physician. I thank you.

REP. AMANN: Thank you, Doctor. Any questions? Being none, thank you very much. The next speaker is Warren Ruppap followed by Jerry Patton.

WARREN RUPPAR: Good afternoon, Representative Amann and members of the Insurance and Real Estate Committee. My name is Warren Ruppap and I'm the Executive Vice President of the Independent Insurance Agents of Connecticut. I come to you today to voice our concerns on HB 5365, An Act Concerning Premium Billing Notice for Commercial Insurance. Basically our Association agrees with one of the provisions or two of the provisions in the bill and have some concerns as to the way the rest of the bill is worded. There is an allowance here in the premium billing notice that a notice would not be required for a policy where the premium increases less than ten percent on an annual basis.

We would agree with that as that would create some efficiencies that are not currently in the statute. It would ease some of the market conduct constraints and problems that the companies have noted and would allow for, I think, a more

convenient transaction on a renewal notice with the insured knowing up front that if they don't receive the premium billing notice they already know that it's a ten percent or a less than ten percent increase and they can appropriately shop the risk if they want to with their agent. The other area that we would agree with too is that any personal risk be subject to the 30 day requirement as well.

From there we have some problems with the bill. In lines 61 through 65 of the bill it talks about a commercial risk insurance policy where the annual premium for the insurance's entire commercial risk account, including any worker's comp policy, was less than \$50,000 for the preceding annual policy period. To include worker's comp and all policies for that account from one insurer is very, very difficult and quite -- in fact would probably negate the \$50,000 threshold. Worker's comp premiums being as high as they are, the entire accounts being as high as they are, you would reach that threshold very, very quickly and I don't have any numbers nor I would be willing to guess, but I'm sure that there are many accounts in this state who currently have the benefits of the premium billing notice today who would lose that benefit on a policy per policy issuance.

Also to include the worker's comp premium in here, there are many worker's comp policies which are self insured risks, which are retro plans where the premium would change, and so that there again there would be a difficulty to quantify this. And lastly in this particular area, it would be difficult for market conduct in the insurance department to take a look at the policy transactions on an individual basis and not understand exactly when a premium billing notice should be sent out because I don't believe the market conduct takes a look at the entire account that the premium would generate nor would they probably have that information available if the account was broken up through several insurers. If they're doing one particular market conduct review they'd be looking at one particular policy and that policy transaction. That's the purpose, I think, of the market conduct to make

think that there is a great disparity between the resources allocated in the health care area for children and for virtually everyone else. And that there is much more that can be done in a prevention and catching different infirmities at the earliest stages of life than can be done for many of us who are older.

And so that there is something backwards about a system that limits a newborn infant to one day length of stay and grants the rest of us an extended period of time to recover from diseases which often could be prevented in the first place. So on the basis of prevention and for catching things that we couldn't otherwise track in a 24 hour period and also to protect the children, newborn children in this instance, and balance the scale a little bit in terms of resources allocated in a cost effective manner we would ask the Committee to support Raised Bill 330 and we appreciate the opportunity to bring this testimony before you today.

REP. AMANN: Any questions? Senator Munns.

SENATOR PAUL MUNNS: Thank you, Mr. Chairman. Joe, say this bill passes, okay. Do you think that there is going to be a number of patients that will still go home after one day or do you think that they're going to just stay for two days?

JOE COATSWORTH: It's hard to tell but I think that as a physician who testified earlier noted that at least the control of whether the patient left in 24 hours or 48 hours would be with a medical professional and that that might make all the difference in the world. So that it's hard to say with any degree of certainty, but at least there would be some assurance that somebody medical would be involved in making that determination.

SEN. MUNNS: In all due respect, as you know the cost to stay in a hospital is pretty high for a day and the insurance companies are basically serving as the payor because the insured really doesn't care because they're not paying the bill. Would you object, say two years from now, that we find that

99 percent of the people are staying for the entire two days because of this law and it really isn't medically necessary, would you object to this issue being revisited? Because, again, the insurance companies, say there were no insurance companies, you'd probably hear a lot more from your patients. Would you object to this being revisited?

JOE COATSWORTH: Well it's been my experience that most issues are revisited here every six or eight months whether I want them to or not that seems to be customary and for good reason. So I think that it's incumbent upon all of us to track what does happen during the next year or so and see if there is any change in the length of stay. And if there is, if there is some benefit that could be measured, which I think there will be, associated with that. But I think that, I think the Legislature is free to reexamine all these issues -  
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SEN. MUNNS: The reason I brought that up, Joe, and I appreciate it, if I'm still here and if you're still here, I would be curious to see how much those statistics change.

JOE COATSWORTH: Right.

SEN. MUNNS: Thank you.

REP. AMANN: Any further questions? Hearing none, thank you very much.

JOE COATSWORTH: Thank you, Mr. Chairman.

REP. AMANN: The next speaker is Laura Manzione. And the next speaker after that is John Yonkunas.

LAURA MANZIONE: Good afternoon, Representative Amann and members of the Insurance and Real Estate Committee. My name is Laura Manzione. I'm the new Director of the Connecticut Chapter of the National Organization for Women. We have over 6,000 members statewide.

If you couldn't guess, we're here to support SB 330 extending coverage for maternity stay to 48 hours

# Dominic Mazzoccoli

State Representative 27th Assembly District

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29 Cinnamon Road, Newington, CT 06111; 954-2741 or 666-8626

February 26, 1996

Senator Lou DeLuca  
Representative Jim Amann  
Co-Chairman  
Insurance Committee

**RE: Testimony on SB329 AAC Captive Insurance Companies**

Dear Members of the Insurance Committee,

Unfortunately I was unable to testify in person regarding this bill. By enacting this legislation Connecticut will be able to entice companies and associations to locate their captive insurance company in our state. Many large companies and associations formed captives due to the federal tax advantages and because of the special needs served by captives. These companies and associations insure themselves by establishing their own alternative insurance company to manage their own risk rather than going to a traditional insurance company like the Travelers, Aetna or the Hartford.

Captive insurers do business in Connecticut today, but because we do not allow them to domicile here they locate in places like Vermont and Bermuda and do business all over the country. Some examples of pure captives are: Alcoa, AT&T, Cabot Corp, GTE, Hallmark Cards, Johnson & Johnson, Merrill Lynch, Mobile Oil, Toyota, Wang and Weyerhaeuser. Some association captives include:

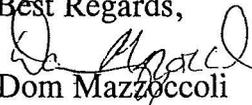
Universities, ski areas, housing authorities, accounting and many others. The Hartford Housing Authority insures its' property with a captive that is domiciled in Vermont. The premium volume generated by Vermont captives is approaching 2.5 billion dollars.

You may be asking "If we allow them in Connecticut, won't they hurt the insurance companies that are already here?" The answer is no! They already do business here. In fact they do business with some of our largest insurance companies. So what is the benefit of allowing them to domicile or locate their operations in Connecticut? Allowing them to locate here will bring jobs and premium tax dollars to our state. Many traditional insurance companies will not insure some of the risks that captives will insure. Captives provide a means for these otherwise undesirable insureds to get insurance coverage at a reasonable cost.

Since Vermont set up a captive law in the 1981 the number of captives locating there is now in excess of 250 companies. These companies generate insurance jobs and employment for a host of professional and service companies. Last year Vermont raised 10 million dollars in premium taxes and hundreds of thousands of dollars in fees from insurance written all over the country and in our state. Remember, captives can only insure their parent company or members of their association. They cannot write insurance for homeowners or personal automobiles.

Connecticut has a large base of corporate headquarters facilities and due to our convenient location to New York City and Boston we would be very attractive for companies to locate here. With the loss of insurance jobs in our state, the formation of captives will create job opportunities for those insurance professionals who may have recently lost their job. It will also generate significant premium tax income from captives that locate here. Thank you.

Best Regards,

  
Dom Mazzeccoli

State Representative

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# VT CAPTIVE VITALS

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A publication by the Vermont Captive Insurance Association  
Prepared for the Vermont State Legislature - January 1995

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## BACKGROUND

A captive insurance company is a wholly owned insurance subsidiary of a corporation or professional organization not in the insurance business. It exists for the primary purpose of managing the risks of its parent(s), providing a variety of benefits, including a method of controlling premium costs; access to additional capacity; the ability to provide unique insurance coverages; efficiencies in claims handling and loss control; cash flow and interest earnings on reserves. The majority of captives are pure, meaning they are 100% owned by a single entity. However, there are numerous group captives, both industrial insured groups, and association sponsored captives, and "risk retention groups", which are companies licensed under federal risk retention legislation and operating as captives.

Normally, insurance companies are licensed to provide insurance to all or a variety of citizens of a state, either individuals or corporate. The traditional insurance industry is regulated in each state to protect its citizens. Captive insurance companies, by contrast, directly insure only their owners, who are sophisticated insureds, with the ability to manage and retain their own risk. Consequently, the thinking is that legislation aimed at consumer protection, such as the traditional regulation of capitalization, accounting methods, control of investments, premium rate, and policy form, is not necessary.

For several decades, especially in the 1970's when the captive movement gained momentum, most captive companies were formed off-shore to escape the regulatory environment existing in the U.S. Bermuda became the domicile of choice, currently with approximately 1,300 companies licensed. Grand Cayman, B.W.I., were next with about 365 companies, and many other domiciles were established world-wide.

In 1981, Vermont recognized the potential benefits to the State of attracting captive insurance companies and passed legislation providing the appropriate regulatory and taxation environment required by the industry.

The result of this foresight is that there are currently 264 active captive insurance companies in the State, with Vermont being the state with the most U.S. domiciled captives. The Vermont laws and regulations serve as the model for other states, which are competing in the same arena and are trying to entice Vermont captives to move to their state or compete with Vermont for new licenses.

### Vermont Continues to be the Leader

In 1994, as in previous years, the industry and the state worked together to develop legislation which would allow Vermont to retain its competitive position as a premier onshore domicile. A tax rate reduction for business assumed from ceding companies was introduced. In many cases this helps insureds to use their captive more effectively in the control of workers' compensation costs. By increasing the benefits that result from captive ownership, Vermont promotes the growth of the captive industry, and the resulting benefits to the state. Additionally legislation was enacted to clarify the regulations and procedures applicable to Risk Retention Groups, including the introduction of licensing procedures for third parties who have authority over the underwriting and claims settlement process.

In all instances where Vermont has revised its captive legislation, there has been a single overriding objective, that of maintaining a healthy domicile for insureds who need to utilize alternative methods of managing their risks. Recognizing that the alternative market requires a different regulatory approach from the traditional commercial insurance market, Vermont has succeeded in creating a regulatory environment in which the interests of the host state, and those who derive the benefits from the captive industry, are equally protected. As Vermont continues to work with the National Association of Insurance Commissioners to achieve accreditation, it is vitally important, for the ongoing health of the domicile, that Vermont's ability to regulate in a manner appropriate to the unique needs of the alternative market is maintained.

Vermont is the domicile of choice for corporations in search of alternative risk financing. Vermont also has twice as many captive insurance companies as all other U.S. domiciles combined. Examples of corporations which have formed pure captives, and examples of the types of companies which have formed captives follows:

### Parent Companies of Pure Captives

- Alcoa
- Ameritech
- Archer Daniels Midland Company
- Ashland Oil
- AT&T
- Cabot
- Cargill
- Citicorp
- Consolidated Freightway
- CSX
- Hallmark Cards
- Hewlett-Packard
- Hilton Hotels
- Merrill Lynch
- Mobil Oil
- Montgomery Ward
- Paine Webber
- Santa Fe
- Southern Pacific
- Six Flags
- Southwestern Bell
- Wackenhut
- Toyota
- U.S. West
- Wang
- Weyerhaeuser

### Types of Companies Which Have Formed Group Captives

- Colleges
- Universities
- Hospitals
- Pharmaceutical Companies
- Accounting Firms
- Commercial Banks
- Federal Banks
- Financial Planners
- Ski Areas
- Health Care Systems
- Law Firms
- Catholic Dioceses
- Plastics Industries
- Engineers
- Chemical Industries
- Housing Authorities

(Source: VCIA - January 1995)

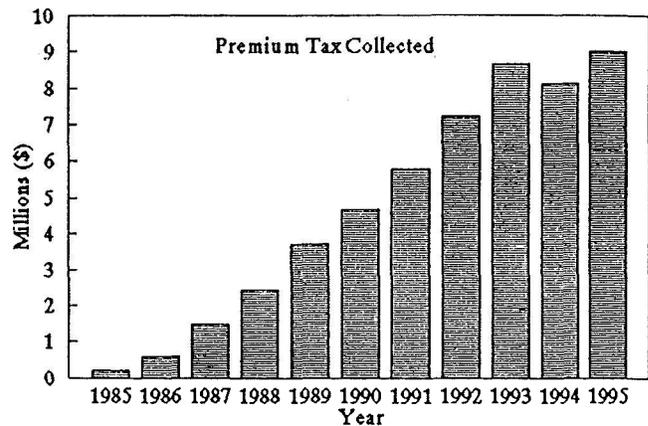
## ECONOMIC BENEFIT TO VERMONT

Although rarely publicized, this industry about which the general public has limited awareness or understanding of, it undoubtedly been the fastest growing industry in the State in recent years. As can be seen in the following information, the financial impact is significant to the State.

### Premium Taxes Collected

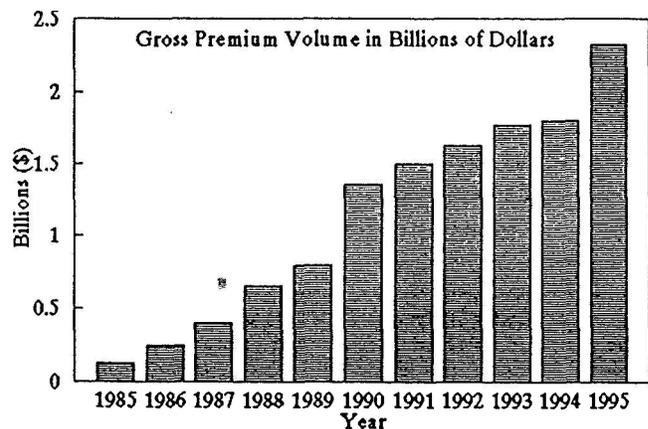
(for prior calendar year)

1985	\$ 231,208
1986	596,761
1987	1,496,369
1988	2,460,069
1989	3,711,022
1990	4,693,000
1991	5,789,117
1992	7,212,571
1993	8,655,037
1994	8,129,693
1995	9,000,000 (Est.)
<b>Total</b>	<b>\$51,974,847</b>



### License and Examination Fees Collected

1982	\$ 1,800	1989	170,179
1983	5,700	1990	161,069
1984	8,400	1991	173,042
1985	11,600	1992	146,431
1986	27,600	1993	172,435
1987	45,968	1994	200,000
1988	82,274	<b>Total</b>	<b>\$1,206,498</b>



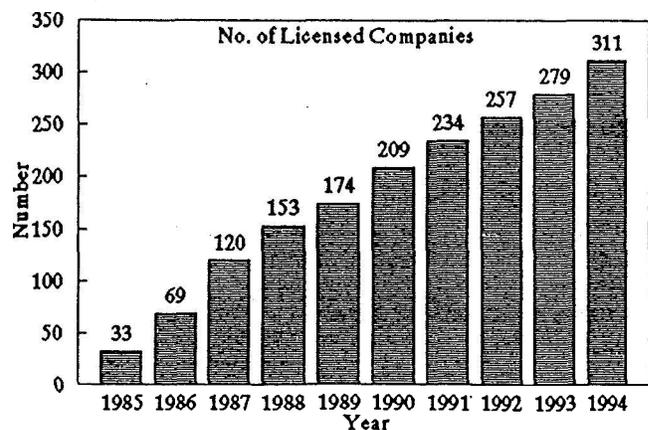
Vermont has more than twice as many captive insurance companies as all other U.S. domiciles combined. Examples of corporations which have formed pure captives or group type captives follows:

#### Parent Companies of Vermont Pure Captives

*Alcoa, AT&T, Cabot, Citibank, GTE, Hallmark Cards, Johnson & Johnson, Merrill Lynch, Mobil Oil, Montgomery Ward, Toyota, Wang Laboratories, and Weyerhaeuser.*

#### Types of Vermont Group Captive Industries

*Accounting and Actuarial Firms, Airports, Catholic Dioceses, Chemical Industries, Engineers, Financial Institutions, Hospitals, Law Firms, Ski Areas, and Universities.*



## **THE BENEFITS DERIVED FROM THE CAPTIVE INDUSTRY**

### **SPECIFIC BENEFITS OF A GROWING "ART" MARKET FOR THE STATE OF VERMONT:**

- Premium Tax Revenues
- Job Creation
- General Expenditures:
  - Office Space Rental
  - Local Professional Services and Banking Facilities
  - Board Meetings in Vermont
  - VCIA Annual Conference Attendance
  - Support of Vermont Insurance Institute
  - Fund raising for IBM Write-to-Read project

**STATEMENT****INSURANCE ASSOCIATION OF CONNECTICUT****RCB 329, An Act Concerning Captive Insurance Companies****Insurance and Real Estate Committee****February 27, 1996**

The Insurance Association of Connecticut urges the Insurance and Real Estate Committee to proceed with caution regarding RCB 329, An Act Concerning Captive Insurance Companies, as the potential effects of this legislation are not clear at this time.

RCB 3219 is intended to provide a regulatory structure for captive insurers that would serve as an incentive for them to locate in this state. The proponents believe that increased tax revenues and insurance jobs will result from the passage of the bill.

Connecticut is relatively late to the idea of creating a haven for captive insurers. Vermont has had a similar law on the books since 1981. Other states have passed similar provisions in recent years. There are only so many entities that can make use of such a law. Can we assume that captives sited in other states will move to Connecticut? Vermont has generated a total of only 150 jobs from their captive law. Other states with captive laws have not generated windfall tax revenues. Why would Connecticut be different?

Obviously the IAC's preference would be for the General Assembly to seek additional ways to improve the business climate for its existing domestic insurance industry. What is the potential effect of RCB 329 on that industry? It may be instructive to point out that political support for similar legislation in Rhode Island has waned due to the potential adverse impact on its domestic insurance industry.

Compared to Connecticut, Vermont has a very small domestic insurance industry, so little was put at risk in adopting a captive law there. RCB 329 tries to incent the creation of captives by, among other things, markedly reducing their tax liabilities to the state, minimizing the capital and surplus requirements for licensure, and exempting them from the separate assessments domestic insurers pay to fund the Insurance Department. To the extent these captives will be writing the same types of insurance and traditional insurers write in Connecticut, the potential for unfair competition is real. Experience has shown in other states that the Insurance Department may not be set up to regulate these new entities, and additional costs will be incurred to develop necessary regulatory tools.

It is also not clear how sections 19 to 29, concerning risk retention groups, relate to chapter 693c of the general statutes, which already regulate such groups. It is not clear how sections 30 to 34 of RCB 329, concerning managing general agents, relate to Connecticut General Statutes 38a-80 to 38a-90h, which regulate managing general agents.

The Insurance Association of Connecticut would welcome the opportunity to work with the General Assembly and the Insurance Department to determine whether, on balance, the potential effects of RCB 329 would be in the best interests of the state and its citizens.

SB330

Good morning. My name is Heidi Galan, and this is my husband, Ed, and our daughter, Elizabeth. We are here to testify in support of the Legislature passing a Bill in favor of a mandatory 48 hour stay for a normal vaginal delivery and 96 hours for a cesarian section.

My husband and I had our first child, Elizabeth, on September 20, 1994. I had a normal pregnancy and a normal delivery. Elizabeth was born very healthy; and in fact, her Apgar scores were 8 at 1 minute and 9 at 5 minutes. The highest score a child can obtain is 9.

On September 21st, my sister, Rebecca, was visiting Elizabeth and I in the hospital. (She is currently a R.N. at Boston Children's Hospital.) Rebecca brought to my attention that Elizabeth was having very rhythmic movements, which is usually a sign of seizures; and she wanted me to bring this to the nurse's attention immediately. This occurred 36 hours after Elizabeth's birth.

After speaking with the nurse, she decided that it was best to bring Elizabeth back to the nursery so that they could monitor her more closely. About five minutes later, Rebecca and I went down to the nursery to see how Elizabeth was doing, and we found out that Elizabeth had stopped breathing and resuscitative measures had to be taken. She was then transferred to the Neonatal Intensive Care Unit for further care.

Within the next 24 hour, the doctors told us that Elizabeth had a massive intracerebral hematoma on the right side of her brain. The bleed had stopped, but they were unsure what caused it or if it would start again. They had been treating her with Phenobarbital to control the seizures; and for the time being, they were going to continue with this treatment and see how she progressed. They indicated, that in time (weeks, months, or possibly longer) that her body would eventually absorb the clot.

Within a few days, the neurosurgeon came to my husband and I and indicated that he felt that Elizabeth should undergo surgery to remove the clot. It had stopped bleeding, but it could take weeks or months for the body to reabsorb the mass, and he felt it was more beneficial to remove the clot since they did not know the cause of it or if it would start bleeding again.

PCSW Testimony - Maternity Stay  
February 27, 1996

page 2

also allows a range of choice for the mother *and* will reduce medical costs because it will lead to a higher rate of early detection and treatment for post-partum health problems. It is an important part of the legislation.

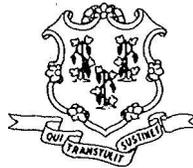
Why do we need this bill? As you know, when the Attorney General surveyed insurers late last year, he found that 14 out of 20 insurers had a clear 24 hour limit on normal deliveries. Some insurers and some physicians who testified in January indicated that there were significant pressures put on providers to discharge women and infants within 24 hours, and sometimes sanctions against those who recommended a longer stay.

The Center for Disease Control (CDC) estimates that 14% of women and 11% of newborns experience complications after discharge. Common problem such as jaundice or dehydration cannot be detected within 24 hours. In the worst possible cases, these conditions, if undetected, lead to brain damage. But even in the best possible cases, as Dr. Leonard Banco testified at an earlier hearing, it is hard to justify a policy in which we let an infant leave the hospital before we know whether he or she can successfully accomplish basic human functions such as eating and eliminating.

There are two areas of concern I would like to discuss: First, we are concerned that an adequate length of stay be guaranteed not only to mothers covered by public or private insurance, but to uninsured women as well. Therefore, we ask the committee to consider a new section requiring hospitals to observe the same childbirth and maternity protocols and provide the same length of stay for all patients, regardless of whether or not they have insurance coverage. This language is included as Section 3 in the house version of the bill, H.B. 5313, which was raised by Public Health, and we urge this committee to consider that section favorably.

Second, we wish to make very clear that nothing in this proposed legislation nor in our strong support for it should be misunderstood to imply that 2 or 4 day hospital stays are mandatory or even best for all women. It has taken us a long time to change public perception and policies to recognize that childbirth is usually not a medical emergency but a healthy, planned event and that a mother might choose to give birth in a variety of settings with a variety of qualified health care providers to assist her. We do not wish to go backwards. This legislation only requires that coverage is available, not required, and that neither a mother and nor her health care provider should be penalized if she needs to stay longer, or if she wishes to go home as soon as possible.

Thank you for considering this important health care issue.



State of Connecticut  
 HOUSE OF REPRESENTATIVES  
 STATE CAPITOL  
 HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE CHRISTEL H. TRUGLIA  
 ONE HUNDRED FORTY-FIFTH DISTRICT

7 GYPSY MOTH LANDING  
 STAMFORD, CONNECTICUT 06902  
 TELEPHONES  
 HOME: 357-7786  
 CAPITOL: 1-800-842-8267

ASSISTANT MAJORITY LEADER  
 MEMBER  
 APPROPRIATIONS  
 HUMAN SERVICES  
 SELECT COMMITTEE ON CHILDREN

**SB 330 AN ACT CONCERNING MINIMUM STAY FOR POST-MATERNITY CARE**

**Insurance and Real Estate Committee  
 Public Hearing February 27, 1996  
 Room 2D 10:00 a.m.**

Senator DeLuca, Representative Amann, and members of the committee, during the winter last year, I had the opportunity to shadow a doctor for a day at Stamford Hospital. At that time I met and spoke personally with many women who were in the hospital for the joyous occasion of the birth of their child.

This occasion for many was less than cheerful due to the fact that they spent as much time checking their watches for the time in order to make sure they did not enter the hospital too late in the day because their 24-hour stay might be spent in labor, leaving little time available for recovery for both the new mother and the newborn.

I believe a 24-hour release requirement after childbirth is a terrible policy. It is concern for the health and well-being of both the mother and newborn child that led me to sponsor a bill requiring insurance companies to provide coverage for a minimum 48-hour hospital stay for normal deliveries, and longer stays for deliveries by Caesarian section.

I believe that discharges from the hospital after childbirth should be determined by the clinical judgement of attending physicians and the needs of the mother and infant, not by economic considerations.

During the time I spent with maternity doctors and nurses, I learned of several serious health complications that can develop in newborns during the first hours and days after birth.

Rep. Truglia Testimony (page 2 of 2)

These complications include jaundice, which can lead to brain damage and mental impairment, motor loss, and hearing impairment if left untreated. A mother alone can not be expected to diagnose jaundice that would require treatment, even doctors can not always agree on it.

There have also been cases of breast-fed babies suffering from malnutrition and dehydration because mothers did not realize their babies were not getting enough milk. These potential problems certainly would be detected with a second day of hospital care with proper instruction in breast feeding.

There are also risks for the mother in an early release. They are often exhausted and sore. They need a good night's sleep, and time to learn how to take care of their newborn and themselves before they leave the hospital.

In closing, I would urge this committee, and the entire General Assembly, to follow the lead of New Jersey and Maryland in requiring coverage for 48 hours of hospital care after childbirth.

RICHARD BLUMENTHAL  
ATTORNEY GENERAL



55 Elm Street  
P.O. Box 120  
Hartford, CT 06141-0120  
(860) 566-2026

Office of The Attorney General  
**State of Connecticut**

**TESTIMONY OF  
ATTORNEY GENERAL RICHARD BLUMENTHAL  
BEFORE THE INSURANCE AND REAL ESTATE COMMITTEE  
FEBRUARY 27, 1996**

I appreciate the opportunity to speak in strong support of Senate Bill 330, An Act Concerning Minimum Stay For Post Maternity Care.

Although a father is well advised to be particularly humble and respectful when speaking about childbirth, plainly it is one of the most physically and emotionally demanding experiences in a woman's life. At the same time that a woman is physically recovering after childbirth, she must also address the rigors of caring for a newborn. For any new mother -- first-time or otherwise -- these challenges include bonding with a new baby, learning to feed and comfort, changing diapers, giving baths and understanding a baby's signals. For each baby, these tasks will vary, along with the particular character, temperament and physical needs of the baby. During these first days of infancy, babies are also particularly susceptible to certain illnesses, such as jaundice, which need to be diagnosed and treated very quickly.

Although week-long hospital stays after childbirth were common twenty-five years ago, mother's desires to return home with her children to begin nurturing them in a home environment caused the average length of hospital stays to be reduced to two to three days over the past two decades. Despite this trend, however, insurance coverage for longer hospital stays remained available.

In recent years, the average hospital stay after childbirth has been drastically reduced -- in some instances, to less than 24 hours after natural childbirth. The reduction is not a response to the desire of women to begin nurturing at home. Rather, its objective is to drive up profits.

Several months ago, my survey of 20 companies found that only 4 insurers provided insurance coverage for hospital stays of more than 24 hours after childbirth. Our survey covered insurers, health maintenance organizations and preferred provider organizations that provide health insurance in our state. I have attached a summary of the results of that survey.

This reduction in coverage has taken place despite the fact that not a single empirical study demonstrates that hospital stays of less than 24 hours after natural childbirth will have anything but a potentially negative effect on the newborn's health. A review of the abstracts of several studies purporting to address this issue demonstrates that each of them has major flaws in its analysis, either through the lack of an adequate control group or that the study group was not

subject to mandatory maximum hospital stays. Pediatricians and gynecologists will attest that the first several days of a baby's life require close monitoring. To be sure, this monitoring can be conducted by a specialist in the mother's home. However, in some instances, the mother is simply not prepared, emotionally or physically, to deal with the pressures of motherhood without some constant, closer assistance.

Also according to my survey, although many insurers provide coverage for more than 24 hours after childbirth if medically necessary, some insurers apply sanctions to physicians who request hospital stays beyond that of the average. These sanctions are not only directly financial, sometimes they include dropping the physician from the list of approved physicians.

Finally, my survey shows that no insurers inform the mother or father of policy limit presumptions for post childbirth hospital stays. Thus, most new parents are surprised to learn that their insurer will not authorize a hospital stay of longer than 24 hours.

The legislation that is before this committee, therefore, is absolutely essential to preserving the best care for our mothers and newborns.

It will restore the balance between insurers' desire to reduce health care costs and the physician's ability to protect the health of the mother and newborn. This legislation will enable mothers to make informed, wise choices based on their particular needs, and in consultation with their families and doctors. It will not require hospital stays of any specific length, but will simply enable mothers to stay in the hospital for the appropriate amount of time.

Although some enlightened insurers are now providing coverage for hospital stays of 48 hours after natural childbirth and 96 hours after cesarean birth, this legislation will level the playing field for all insurers by stating very clearly that the public policy of the State of Connecticut demands insurance coverage for adequate hospital stays after childbirth in order to protect the health of both mother and the child.

I especially commend the Insurance and Real Estate Committee for including in this proposal a critical provision requiring insurers to notify consumers upfront of their limits on hospital stays after childbirth, prohibiting insurers from sanctioning physicians who request longer stays in certain cases and ensuring that home visits are conducted by properly trained specialists in the field of post-partum care for the mother and child.

I urge your consideration of two additional provisions. First, this legislative proposal should include a section requiring hospitals to provide the same minimum stay after childbirth and follow-up care as is required of health insurance companies in Senate Bill 330. This provision, contained in House Bill 5313, would ensure that mothers and children who are covered by an employer's self-insured health plan receive the same protection as mothers and children who are insured by a licensed health insurer.

Such a provision is critically important. Almost 50% of Connecticut's workers are insured by an employer's self-insurance health plan. These plans, used mainly by large employers, cannot



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February 27, 1996

**STATEMENT OF BLUECROSS BLUESHIELD OF CT, INC.  
REGARDING S.B. 330, AAC MINIMUM STAY FOR POST MATERNITY CARE**

Good Morning Senator DeLuca, Representative Amann and members of the Insurance and Real Estate Committee. My name is Emily C. Smith and I represent BlueCross BlueShield of CT, Inc., the state's largest managed care company. I am here today to discuss BCBS's maternity discharge program, as it relates to our HMO and managed care products, and answer any questions you may have regarding it.

As most of you know, on December 20, 1995 BCBS of CT launched a communications campaign to clarify its maternity discharge program. Since the inception of the program in April 1995, much confusion about it existed and a lot of misinformation was circulating. This led us to undertake a review of the program and the procedures we had put in place to support it. Following the review, we determined that certain clarifications and adjustments were needed to maintain the integrity of our maternity discharge program.

Perhaps the most significant "procedural" change we made has to do with the authorization letter we send to our member and her doctor once her maternity stay is precertified. Prior to December 20th, our members were automatically authorized for a 24 hour hospital stay following an uncomplicated vaginal delivery. While the ability to extend the length of stay for medically necessary reasons existed, many providers wrongly believed such a request would jeopardize their standing in our network and were hesitant to request an extension. This issue was perhaps the biggest cause of confusion. Those providers who did request a longer length of stay were, 99% of the time, granted the additional day, but still, the misconception stood that we had a firm 24 hour discharge policy and that no one was allowed additional time.

To eliminate any further confusion about the length of stay issue we are now automatically precertifying our members for a 48 hour hospital stay and only requiring additional authorization for a length of stay beyond 48 hours. The opportunity still exists for a mom to be discharged within 24 hours of delivery if her doctor believes it is medically appropriate for her to do so. In those cases a generous home care benefit is available to the mother and baby as well as one additional pediatric visit.

This home care benefit is another area we targeted with our recent communications campaign. Previously, mothers who were discharged under the 24 hour program were also eligible for the home care/pediatric benefit mentioned above. However, we found that most of our members were not taking advantage of it. The member was responsible for coordinating the benefit, and as a

result, it wasn't being used. We have now changed the procedure so that all of the coordination and scheduling of the home care benefit is handled by the hospital and the home care agency. Now, mom can just sit back and enjoy the benefit.

Our goal at BCBS is to provide quality benefits for the appropriate, medically necessary care of our members. This issue of short maternity stays has become so controversial and highly charged that we felt our ability to achieve this goal was being impinged upon. It is our hope that the recent communications we have sent out will eliminate any confusion our members and providers may have encountered and will reassure everyone that healthy mothers and healthy babies are our primary concern.

attachment:   press release  
                  News Bulletin  
                  Hartford Courant article  
                  New Haven Register article

SB330

global marketplace. The tax policy of a state is a critical factor to be considered by insurers who, of economic necessity, must regularly evaluate whether they will retain or expand their job base in a state. A consistent and fair tax policy is extremely important.

Connecticut is one of only a few states that impose both a premium tax and a corporation business tax on its domestic insurers. In addition, the state's property taxes are comparatively high, especially in urban areas.

In 1994, the General Assembly made a positive step in changing the state's tax policy by adopting C.G.S. 12-217t, which provided all businesses a tax credit for property taxes paid on data processing equipment. For insurers, that credit could be used against corporate income tax and premium tax liabilities. This credit was especially important for insurers, who are highly dependent on data processing equipment and who usually site that equipment in urban areas.

However, in 1995 the General Assembly amended C.G.S. 12-217t, before it could be initially invoked, to prevent insurers from using the tax credit against premium tax liability for two years.

### Another Way to Thwart Car Thieves

Dear Dr. Gridlock:

Regarding your recent column on auto theft: Several years ago I read in a brochure from my auto insurance company (USAA) that they offered a 15 percent discount on comprehensive coverage for having the vehicle identification number (VIN) permanently etched into the windows.

Having the VIN numbers in the windows discourages thieves from stealing a car by making it far more difficult to change the VIN numbers in order to sell a car.

The Kentucky State Police instituted a program where they marked the windows in 130,000 cars and only four were stolen, of which three were recovered almost immediately.

The most attractive feature of this system is that you never have to turn it on and off, it is not a hassle to use like a steering wheel lock, and most of all it is inexpensive.

CHARLES C. COTTRELL  
Upper Marlboro

Kentucky State Police confirm your report, Mr. Cottrell. They have been doing the etching themselves since 1980, free of charge to the public, and report the kind of success you note above.

Having VIN numbers etched in glass, all the way around the car, makes life more difficult for a thief, who otherwise could simply pry off the dashboard-mounted VIN number and replace it with a VIN number from a legally purchased junk car. To disguise the theft of an etched car, the crook would have to replace all the glass in the car or risk having conflicting VIN numbers on the dashboard and in the glass.

The numbers are about the size of typewriter type and are put on with a stencil and glass-eating acid compound.

D.C. police and Virginia and Maryland state police do not provide the etching service, although they encourage any efforts that will make cars harder to steal. Some insurance companies offer reductions in premiums for using the window-etching kit. One simple, do-it-yourself kit mentioned by Kentucky State Police is called Thief Beware, available through a Fort Worth company. The kit costs \$20. For more information, you can call the company at 1-800-972-1018.



A Kentucky trooper uses a window-etching kit.



SEPTEMBER/OCTOBER 1992

## *Auto Theft Is Robbing Us Blind*

BY JOHN ARCHER

*Auto theft is not just a crime of impulse performed by joy riders. Today's sophisticated car thieves are costing us billions of dollars in taxes and insurance premiums, and it's getting worse:*

- \* An auto theft now occurs every 22 seconds in the U.S.*
- \* 49 out of 50 culprits escape punishment.*
- \* More than 1.6 million motor vehicles were stolen in 1990, an increase of 34 percent since 1980.*

*These thefts cost more than \$8 billion annually - not including uncompensated costs such as lost work time, law enforcement, and higher insurance premiums. In fact, in some states, 88 percent of the comprehensive auto insurance premium is attributable to theft claims.*

*Many stolen vehicles are never recovered. They're either shipped overseas or dismantled in "chop shops" and sold for parts and scrap metal. A car's parts can be worth four times more than the car itself.*

*Recently, Rep. Charles Schumer (D-N.Y.) and Rep. F. James Sensenbrenner (R-Wis.) introduced legislation (H.R. 4542) to fight auto theft. It requires parts to be marked with the vehicle identification number (VIN), so police officers can better identify stolen parts and honest repair shops know they aren't dealing in stolen goods. The bill also allows state motor vehicle departments to verify out-of-state titles more easily. To stop the export of stolen cars—a growing problem—the bill directs the Customs Service to spot-check cargo containers that may hold stolen vehicles.*

*AAA strongly supports H.R. 4542, as do major law enforcement groups, consumer organizations, and insurers. We're urging Congress to pass it before adjourning in October, but we need your help.*

*Tell your congressional representative that you're angry about auto theft and want action on the Schumer-Sensenbrenner auto theft bill. Write to your representative, U.S. House of Representatives, Washington, DC 20515.*

*John Archer is managing director of AAA Government Affairs.*

April, May, June 1990

## VIN LABELS STICK CONVICTION ON AUTO THIEVES

Auto theft investigators are constantly on the look out for tools that help them identify and apprehend criminals. Vehicle Identification Number (VIN) labels are one such tool. These security labels help stick convictions on auto thieves as well as they adhere to doors, hoods, bumpers and fenders.

Connecticut State Trooper Tim Dumas explained the value of VIN labels at the annual IAATI Conference in San Diego last summer. During his lecture, Dumas described a number of successful investigations where security labels played an important role. One incident, which Dumas recalled in a recent interview, drew laughs from IAATI members attending the meeting.

Dumas was driving an unmarked Camaro Z28 down interstate 91 early one evening. He was on his way to a meeting when he heard an Officer in Need of Assistance call. Since he was already heading the right direction, he accelerated, only to hear that the situation had been resolved.

Out of nowhere, a shiny new BMW passed Trooper Dumas "like a shot" going in excess of 100 miles an hour. Dumas chuckled at the thought. He knew dozens of officers were grouped at the bottom of the nest rise, having just converged on the now under control scene.

"Hey, anybody down there got their radar set?" Dumas radioed ahead. He knew chances were good that at least one of the many cops would get set up in time. In fact, it was overkill in excess. "I started to worry that I might get retina damage with 50 radar sets pointed at me," Dumas joked.

It was no laughing matter to the speeders. The driver and passenger must

have felt like two flies caught in the middle of a spider convention. They gave up without a struggle.

The BMW had out of state plates and a temporary registration. Because the ID number on the dash had been damaged, the cops figured they were looking at a stolen vehicle. Nevertheless, speeding is not a crime for which someone can be held. And by the time probable cause could be established, the two men could easily flee across state lines.

Fortunately, the cops had VIN labels on their side. Several of the VIN labels applied by the manufacturer on key parts of the car had been tampered with—a misdemeanor under state law. The suspects could be held long enough to search the car. Fortunately, the crooks had missed one of the VIN labels, providing the police with the car's true identity.

"So, within a matter of ten minutes, on a roadside stop, that label allowed us to get information we needed to charge those people with auto theft," recalled Dumas. Moreover, the arrest led to the Search and Seizure Warrant where the police recovered a stolen new truck and bogus copies of registrations. "I credit the security labels for expediting that," added Dumas. "It's no small thing."

The story is just one out of many. "VIN labels are an invaluable tool for law enforcement," says Dumas. Not only do they help prosecute criminals, they also make illegal distribution of major parts much more difficult. "When I go into a junk yard, I can tell immediately if a transmission or hood or whatever is stolen," says Dumas. Without VIN labels, there's no way to tell."

The statistics on auto theft are staggering. Auto theft rises each year, according to the National Automobile Theft Bureau (NATB). About three thefts occur each minute, costing Americans billions of dollars each year.

At times auto theft is tied to drug trafficking and other serious crimes. In

one stolen car ring Dumas investigated, the suspect "murdered several of the potential witnesses in our case."

To combat this growing problem, the federal government made VIN labels mandatory on certain models. However, several manufacturers receive exemptions on those models equipped with a qualifying alarm. This loophole is known as the "Black Box Exemption."

Dumas fumed, "it is totally absurd that (certain cars) have exemptions." He pointed out that alarm systems do not always prevent theft. "We've recovered alarm equipped Firebirds, Camaros, Corvettes and other models frequently that did not have labels because of the exemption." Whereas with the VIN labels, "the car becomes a liability, creating a strong deterrent."

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**"These labels are the best thing since sliced bread for vehicle theft investigators."**

*-- Tim Dumas*

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Expansion of VIN marking would certainly reduce theft and increase recovery rates. Current recovery rates are 28% for motorcycles, 48% for light trucks and 60% for passenger cars. "These labels are the best thing since sliced bread for vehicle theft investigators," said Dumas. "Without them, it severely handicaps the recovery of stolen vehicles."

All these factors demonstrate the importance of VIN labels. By identifying parts and helping detain suspects, they are an essential tool helping auto theft investigators in the battle against auto theft.

## What the experts are saying . . .

"Vehicle marking is a proven way to reduce auto theft and increase the recovery of stolen vehicles."

*FBI*

"Vehicle marking is a mighty weapon against car theft."

*State Farm Insurance Company*

"VIN labels are the best thing since sliced bread for vehicle theft investigators."

*Connecticut State Police*

"[If] the thief removes the labels from the vehicle, the VIN or unique serial number can be read with the aid of a fluorescent light by the investigator."

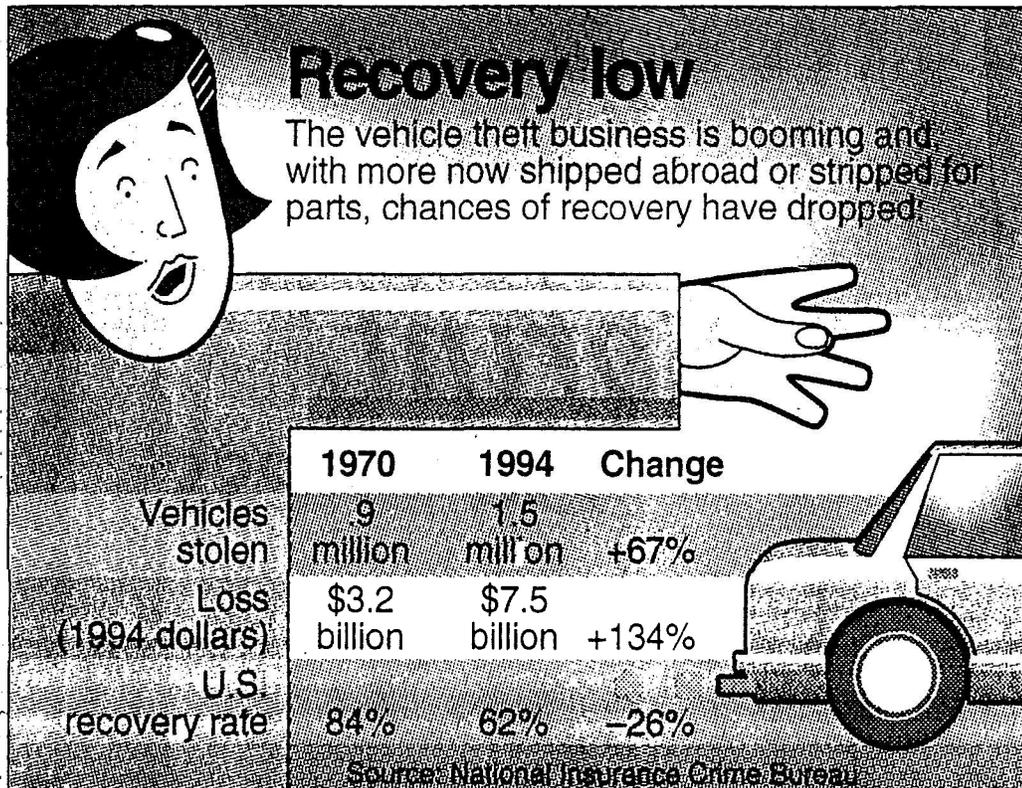
*International Association of Auto Theft Investigators*

"A major reason for the decrease in theft is the growing prevalence of VIN numbers on cars and parts."

*New York Police Department*

## USA SNAPSHOTS®

A look at statistics that shape the nation



By Cindy Hall and Elys A. McLean, USA TODAY

**For USA**



## FACTPAGE

For more information contact:  
NICB News Bureau: 312/856-8887

### Metropolitan Areas with the Highest Vehicle Theft Rate\*

<u>Rank</u>	<u>Metropolitan Area</u>	<u>Theft Rate</u>
1.	Newark, NJ	4,073
2.	Fresno, CA	3,443
3.	Miami, FL	3,001
4.	Tampa, FL	2,933
5.	Detroit, MI	2,751
6.	Bridgeport, CT	2,620
7.	St. Louis, MO	2,600
8.	Springfield, MA	2,449
9.	Atlanta, GA	2,288
10.	Gary, IN	2,209
11.	Boston, MA	2,154
12.	Memphis, TN	2,147
13.	Ft. Lauderdale, FL	2,075
14.	San Bernardino, CA	2,064
15.	Oakland, CA	2,061
16.	Jackson, MS	2,045
17.	Sacramento, CA	2,039
18.	Inglewood, CA	2,033
19.	Cleveland, OH	2,011
20.	Hartford, CT	1,996
21.	Elizabeth, NJ	1,975
22.	Providence, RI	1,958
23.	Kansas City, MO	1,949
24.	New Orleans, LA	1,942
25.	Portland, OR	1,860

\* Based on cities with a population greater than 100,000.  
Vehicle theft rates are based on thefts per 100,000 residents.  
The average theft rate in the United States in 1993 was 605 thefts per 100,000 residents.

State of Connecticut  
GENERAL ASSEMBLY



INSURANCE & REAL ESTATE COMMITTEE  
STATE CAPITOL  
HARTFORD, CONNECTICUT 06106

PUBLIC HEARING - FEBRUARY 29, 1996

10:00 A.M. - ROOM 2D

The Insurance & Real Estate Committee will hold a Public Hearing on Thursday, February 29, 1996 at 10:00 A.M. in Room 2D in the LOB. Sign-up sheets will be available at 9:30 A.M. The first hour is reserved for Legislators, State Agency Heads and Municipal Officers. Please submit 35 copies of written testimony to Room 2800. Testimony is limited to three(3) minutes.

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H.B. No. 5438 (RAISED) AN ACT CONCERNING SHORT-TERM POLICIES

H.B. No. 5433 (RAISED) AN ACT CONCERNING LIFE AND HEALTH INSURANCE POLICIES.

H.B. No. 5435 (RAISED) AN ACT CONCERNING OCCUPATIONAL THERAPY.

H.B. No. 5436 (RAISED) AN ACT CONCERNING INSURANCE COVERAGE FOR TEMPOROMANDIBULAR JOINT DYSFUNCTION.

H.B. No. 5440 (RAISED) AN ACT CONCERNING ACCESS TO EMERGENCY HEALTH CARE.

S.B. No. 286 (RAISED) AN ACT CONCERNING OBRA 90 AMENDMENTS AFFECTING MEDICARE SUPPLEMENT INSURANCE.

S.B. No. 333 (RAISED) AN ACT CONCERNING INSURANCE BINDERS.

S.B. No. 334 (RAISED) AN ACT LIMITING THE FEES FOR TITLE INSURANCE AGENTS.

S.B. No. 335 (RAISED) AN ACT CONCERNING DISPUTED REAL ESTATE DEPOSITS.

S.B. No. 336 (RAISED) AN ACT ALLOWING INSURANCE BROKERS TO SELL TITLE INSURANCE POLICIES.

Legislators

CONNECTICUT GENERAL ASSEMBLY

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Agency  
Municipal

PUBLIC HEARING

PEAKER REGISTRATION

COMMITTEE: Insurance & Real Estate

ROOM NO.: 2D

DATE: 2-29-96

TIME: 10:00 AM.

\*\*\*PLEASE PRINT\*\*\*

NAME

March 13<sup>ron</sup>  
John H.

REPRESENTING

SUBJECT OR  
BILL NO.

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1.	Comme Rider & Staff	Insurance Dept			
2.	Doc Hunter	Sen. Republicans	334, 336	✓	
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excluded from it's requirements.

Workers' comp, accident only, dental, vision, et cetera, and one that was overlooked is short-term insurance policies. Short-term works like this: they are guaranteed issue. They are not underwritten.

If we -- if you were to have a short-term policy, it would come in a self-contained envelope, there would be no health questions, you would figure out how long you wanted it for -- from one to six months, six months maximum -- you would figure out your rate, enclose a check, put it in the mail and you would have \$2 million coverage tonight at midnight for the length of time that you bought it.

Now, in the case of our policy, we include a two-year extension of benefits. So that if you get sick or hurt while you're insured under this policy, the coverage will continue for that condition for another two additional years.

So, for example -- I brought with me just a couple of examples of real-life Connecticut citizens who bought these policies. A 44 year old man had a gastrointestinal hemorrhage. He had bought a six-month, short-term policy. We paid -- we have paid to date, \$168,260 and he has another six months to go on his two-year benefit cycle that we'll continue to pay on that claim if he needs any more.

A 29 year old man, hit by a car, resulting in severe head injuries. His two-year benefit period started in September of '95. Because it happened while the policy was in force, it will continue until September of '97. So far we've paid \$97,000 on that individual.

A 12 year old boy, also in an auto accident, suffered head injuries and his two-year benefit period started in April of '94. And so far, we have paid \$134,000 on that individual.

So it's meeting an important need. 7,000 Connecticut residents bought this type of insurance last year, with their dependents on top of it. And

all kinds of people buy it. You may have a son, for example, or a daughter who quit -- who finishes high school, can't find a job right away, wants to have -- you want that child to have some insurance perhaps.

And you want to find something that's affordable and the child has no medical conditions. A short-term would fill that need. And it ranges all the way to another extreme.

The Clinton administration, when it was elected -- it's transition team bought our short-term policies because they needed some interim coverage. They were going to have permanent coverage later, but they needed interim coverage.

So it's a unique product and portability really doesn't make sense for it because, again, it is guaranteed issue. There are no -- it's an individual product -- but no health questions. You get coverage at midnight tonight and it's very inexpensive.

And we agree with the Commissioner of Insurance. We're more than happy to fully disclose on these policies. That there is no coverage for preexisting -- we already do and we'll be glad to highlight it, if you'd like to.

And with that, I'd be happy to answer any questions, if you have them.

SEN. DeLUCA: Any questions? Ma'am.

DOROTHY THURSON: Thank you, Chairman DeLuca, Chairman Amann, members. My name is Dorothy Thurson. I also represent Golden Rule Insurance Company and I'm here in support of Raised Bill 5433.

This particular bill will allow carriers to attach a life insurance rider to a health insurance policy or a health insurance rider to a life insurance policy. Current law in Connecticut does not allow us to do so. We have a couple of products which we sell in many other states which we're not allowed to sell here in Connecticut because of the law.

For example, we have a decreasing term life insurance rider which is attached to our health insurance policy. And you can have a benefit of up to \$30,000 life insurance attached to your health insurance policy. We can't sell that rider, however, in Connecticut.

The other rider, the health insurance rider, is a brand new one, that we have introduced in a number of other states and what it does is to allow us to extend the long-term care benefits of a life insurance policy, beyond the term that the life insurance policy would provide long-term care benefits.

Briefly, we have a life insurance policy which pre-pays the death benefit for long-term care expenses. That benefit would last for 50 months or so. Some people want the added security of knowing that their benefit will continue beyond that point. And so we have a rider, which is sold separately, funded separately, which would extend those benefits.

We sell the decreasing term life rider in 23 states. Currently it's approved in 34 states. We sell the health insurance rider on the long-term care policy in 35 states.

We think it's a really good benefit for our customers. It provides administrative savings. We're able to provide them with valuable coverage at a less expensive cost to us and, therefore, to them.

There has been an issue raised that possibly this could create some kind of a loop hole for companies -- any companies out there who might not be insured or, excuse me -- authorized to sell both life and health insurance in the state.

That is not our intent and if the Department and others see this as a loop hole, we'd be happy to add any language -- work with them on language that would correct that loop hole and require a license in both areas.

With that, if you have any questions?

SEN. DeLUCA: That was a question in my -- double licensing. My impression of this is that you would need to have a license in both areas to sell both within the state in order to sell the rider -- whichever rider you're talking about, based on the other one -- because they are two distinct, different types of insurance and, therefore, would have to be licensed to sell both.

I guess the Department would have to have some way of ensuring that whomever is selling that, whether it be Golden Rule or any other company, is licensed in both.

So that would be something that I think would have to be resolved. Don't you think?

DOROTHY THURSON: I agree, Mr. Chairman. We certainly can add that language to the bill and I would have no objection. Golden Rule is licensed in both life and health in Connecticut and certainly we would not want to create a loop hole where companies could get around the law in Connecticut.

SEN. DeLUCA: Yes, it's the old story -- we're all honorable here, but it's those other people out there that we have to be concerned about.

DOROTHY THURSON: Absolutely, Mr. Chairman.

SEN. DeLUCA: Representative Chase.

REP. CHASE: I'm just curious on the life insurance riders. What's the marketing advantage -- why would you want to do that? I mean, if you're selling to a small employer, you have a product -- a health insurance product and you have a life insurance product.

What's the advantage to the employer to add a life insurance rider to his health policy for his employees? And does that in any way subsidize the premium of the health insurance in any way?

DOROTHY THURSON: No, Representative Chase. The two are

funded separately. If a small employer wants to add a decreasing term life rider to his group policy -- I suppose he wants to add that to provide an extra benefit for his employees.

I believe that most of these are probably sold on our individual products. And it's individuals who buy our individual health insurance and, therefore, want to have this additional life insurance benefits that they can get at the same time.

REP. CHASE: Okay. So these aren't really group products, they're more individual -- individual policy holders.

DOROTHY THURSON: The bill allows for that to occur -- for that rider to be attached either in an individual situation or a group situation.

REP. CHASE: Thank you.

SEN. DeLUCA: Further questions, comments? Thank you both.

DOROTHY THURSON: Thank you.

SEN. DeLUCA: I'm sorry, we have a question. Representative Eberle. I'm sorry, I didn't mean to overlook you.

REP. EBERLE: I apologize, if you said this earlier, but do any other states allow this?

DOROTHY THURSON: The riders?

REP. EBERLE: This kind of joint --

DOROTHY THURSON: Oh, yes, ma'am. The life insurance rider attached to the health insurance policy is currently approved in 34 states. And the health insurance rider, added to the life insurance policy is currently approved in 36 states.

REP. EBERLE: Okay, thank you.

SEN. DeLUCA: I guess that's it. Thank you. Next is Steve Holland to be followed by Kim, I believe the

last name is Libera, and I apologize if I mispronounce.

DR. STEVE HOLLAND: Senator DeLuca, members of the Committee, my name is Steve Holland. I'm an emergency physician from Saint Mary's Hospital in Waterbury and I'm here representing the Connecticut College of Emergency Physicians. I'm here to speak in favor of HB5440, which is AN ACT CONCERNING ACCESS TO EMERGENCY HEALTH CARE.

I would like to thank Attorney General Blumenthal for his written testimony, as well as the Commissioner and Senator Prague, for their public testimony in support of this bill.

As you've heard, the prudent lay person definition of emergency services is designed to create a situation such that the symptoms from which the patient presents to the emergency department has something to do with deciding whether or not the bill is accepted by the insurance and meets their standards. That's what we feel is the crux of the bill.

What I'd like to do is diverge from my prepared testimony. I've submitted to you written testimony in a green folder. I apologize for the amount of material I've given you, but we've done a lot of work on this and I wanted to present as much reference material to clear up any of the concerns, any of the myths that have been promulgated regarding this legislation.

I would also add that we have tried to help design this bill, and in doing so, have modeled after existing legislation in Maryland, since 1993, which is where the first state that the legislature -- the prudent lay person definition of emergency services --

The definition is not something that we thought up in Connecticut. It's from the American College of Emergency Physicians, and I've included the policy statement on that, toward the end of my testimony.

It is also modeled after HR2011, which is federal

legislation, which is before the federal government, both the House and the Senate right now. And we did that because it is the most scrutinized piece of legislation regarding this.

It is also passed through the GAO, regarding fiscal analysis, and at least on a federal level, they have decided that this was not going to have a major impact on any kind of increase in health care costs.

The first myth that I'd like to address today is the idea that this legislation is going to open up the flood gates to allowing everybody to come to emergency departments.

We heard testimony earlier from the SIGNA representative, Mrs. Harrison, that she thought that there is a possibility that this might double the amount of emergency departments visits and then double and then double again.

With all apologies to this opinion, I feel that that idea is absolutely ludicrous. And I have several reasons for why I think that. First and foremost is that the Maryland experience with this legislation, since 1993, has not shown any increase in emergency department visits.

Second of all the managed care prior authorization is not affected as far as an entity goes. And prior authorization clearly will limit access to emergency departments.

Thirdly, this bill includes the idea that co-payment, which is something which we have used for many years in this country to deter inappropriate visits to not only emergency departments but other areas of health care, is certainly something that should continue and this will deter many visits as well.

And lastly, common sense dictates that if we all have primary care providers, which is apparently the goal in this country, we can get office appointments and we can be seen by a doctor that we know.

I think we have to ask ourselves -- the people in this Committee, the people in this room -- would you go to an emergency department for something you felt was non-urgent, that could be taken care of with your primary care doctor?

And if you feel that way, you would rather see your own doctor, then it's not any different for the people on this side of the desk, it's not any different for the people outside this building. And that same sense is going to continue, regardless of this legislation.

What we're aiming for here is just that people don't have to second guess themselves like this person with this severe headache, trying to decide whether or not they should possibly incur a hefty health care bill, if the insurance doesn't take care of it as opposed to trying to diagnosis for themselves whether or not an emergency exists.

I thank you very much for the time that you've offered me here. Like I said, there's an awful lot of reference material there. If there are any questions, I'd be glad to take care of those now.

SEN. DeLUCA: Thank you, Doctor. Questions, comments? Representative Eberle.

REP. EBERLE: Thank you, thank you Mr. Chairman. Doctor, could you comment on the testimony that was given earlier about Section 4 of the bill, which appears to authorize non-emergency care?

DR. STEVE HOLLAND: I could talk to you about Section 4 in general, which has to do with prior authorization and exactly what that means. What we are saying is not so much for non-emergent care but urgent care. Times when physician's offices are not open, times when they are not available to even see the patient. And that often has to do with after hours.

And this gets into a good concept, because we don't feel we're anti-managed care. We've been working with managed care and will continue to do so because we are their safety net. We take care of

them after hours other times.

What it talks about is, basically, they have 30 minutes to decide, you know, if prior authorization is going to be given or not. If we can't get a call back, and the patient is sitting in our emergency department, to know whether or not their insurance is going to treat them, we felt 30 minutes was a reasonable period of time.

This is the standard that medical consultants are kept to in emergency departments as well. So if we don't get that within 30 minutes, then we feel prior authorization has been made.

If not, if prior authorization is not included during that time period, then there is no statement there that says that visit is paid for -- that is was purposely excluded from the bill.

Then it goes on to talk about what prior authorization means. Prior authorization is given and that includes all of the services that the emergency department is going to have to use to treat that patient, whether it be stabilization, whether it be, you know, complete care. And that has to be covered by the insurance.

It also states that once the prior authorization has been given, then it can't be rescinded. They can't look back afterwards and say that prior authorization was not given or was not meant to be given, unless fraudulent information was given.

So those are the terms that we look at as far as what prior authorization means and what payment is going to occur. It should be based on that. It does not increase payments -- that section is not designed to increase payments to emergency departments or, increase the number of people that are going to be paid for.

That section is to refine the problems that we've witnessed with managed care regarding prior authorization.

REP. EBERLE: Okay. So it's not saying that you should