Document Name	**CID - Insurance Market Conduct and Licensing [1 of 3]**

Naming Format: AGENCY ACRONYM PROPOSAL NUMBER - TOPIC

Please insert a copy of the fully drafted bill at the end of this document (required for review)

Legislative Liaison	Jim Carson
Division Requesting This Proposal	Insurance Department Market Conduct, Licensing
Drafter	Tony Caporale

Title of Proposal	An Act Concerning Insurance Licensees and Market Conduct
Statutory Reference, if any	C.G.S. sec. 38a-8, 38a-15, 38a-16, 38a-790, 38a-792
Brief Summary and Statement of Purpose	This proposal will amend pertinent sections of the Connecticut General Statutes to: (1) authorize the Insurance Commissioner to order restitution in the amount of sums received in violation of insurance laws, regulations or orders plus interest; (2) authorize action in the Hartford Superior Court to enforce any of the insurance laws, regulations or Insurance Commissioner's orders; (3) require any person to comply with investigation or hearing related requests from the Insurance Commissioner within 30 days; (4) authorize the Insurance Department to perform market conduct examinations of third parties providing services to the insurance industry; and (5) change the renewal dates for licenses issued to adjusters and appraiser on the basis of the individual licensee's birth month rather than June 30th of odd-numbered years.

SECTION-BY-SECTION SUMMARY

Summarize sections in groups where appropriate

Section 1: Provides that (1) the Insurance Commissioner has the authority to order restitution in the amount of sums obtained in violation of insurance laws, regulations or commissioner's order plus interest; and (2) authorizes the Insurance Commissioner (or Attorney General on the Insurance Commissioner's behalf) to file action in the Hartford Superior Court to enforce any insurance law, regulation or Insurance Commissioner's order.

Section 2: Provides that any person in receipt of a request for information or documentation from the Insurance Commissioner in connection with an investigation or hearing must comply within 30 days.

Section 3: Authorizes the Insurance Department to perform market conduct examinations of third parties that provide certain services to the insurance industry.

Section 4: Changes the renewal dates for motor vehicle physical damage appraisers to the individual licensee's birth month rather than the current June 30th of odd numbered years.

Section 5: Changes the renewal dates for casualty adjusters to the individual licensee's birth month rather than the current June 30th of odd numbered years.

BACKGROUND

Origin of Proposal **[X] New Proposal** **[ ] Resubmission**

If this is a resubmission, please share the prior bill number, the reason the bill did not move forward, and any changes made or conversations had since it was last proposed: N/A

Please consider the following, if applicable:

How does this proposal connect to the 10-year vision for the agency's mission?	The intention of this proposal is to protect policyholders.
How will we measure if the proposal	Section 1:

successfully accomplishes its goals?	• Restitution: The amount of restitution ordered by the Insurance Commissioner in connection with Market Conduct examinations. • Legal Action by the Insurance Commissioner: The amount of fines/penalties collected following legal action by the Insurance Commissioner.
Have there been changes in federal/state laws or regulations that make this legislation necessary?	No.
Has this proposal or a similar proposal been implemented in other states? If yes, to what result?	Section 1: • Restitution: Yes. Other states allow for restitution in connection with specified violations of the insurance law beyond the unfair trade practices laws (e.g, Ohio, South Carolina). • Authority to File Legal Action: Significantly, this proposed language is found elsewhere in the Connecticut General Statutes including Conn. Gen. Stat. §36a-50(b). In the absence of this language, it is the opinion of the Office of the Attorney General that the Insurance Commissioner is unable to enforce orders. Section 2: Yes. This type of requirement helps regulators avoid unnecessarily protracted investigations/hearings and take timely action. Section 3: Yes. In addition to similar provisions in other states, this proposal is consistent with the Insurance Commissioner's authority to conduct financial examinations of third-party data providers as provided in Conn. Gen. Stat. §38a-14. Sections 4 and 5: Yes. The proposal reflects how licensing renewals are handled in a majority of states
Have certain constituencies called for this proposal?	No. The proposals have been identified by Insurance Department staff as items needed to work more efficiently and effectively.

INTERAGENCY IMPACT
List each affected agency. Copy the table as needed.

[ ] Check here if this proposal does NOT impact other agencies

1. Agency Name	Section 1 (Authority to File Legal Action): Office of the Attorney General
Agency Contact (name, title)	John Langmaid
Date Contacted	10/2/2023
Status	**[X] Approved [ ] Talks Ongoing**
Open Issues, if any	

FISCAL IMPACT
Include the section number(s) responsible for the fiscal impact and the anticipated impact

[] Check here if this proposal does NOT have a fiscal impact

State	Section 1, Legal Action by the Insurance Commissioner: To the extent that the Attorney General is needed to enforce the Insurance Commissioner's orders or otherwise file litigation in the Superior Court, costs may be incurred. The fiscal impact depends on the volume. Based on recent experience, the number of enforcement actions and related litigation costs will be limited. The Office of the Attorney General expects that its current staffing is sufficient to support any resulting litigation. Section 3, Examination of Third-Party Providers. In the event that the Department engages consultants to assist with the market conduct examinations of third-party providers, this cost will be the responsibility of the companies examined with the exception of Connecticut domiciled companies. This type of additional cost incurred in connection with Connecticut domiciled companies will be paid using funds available in the Insurance Fund (funded through the annual assessment of Connecticut domiciled insurers). Exam costs will vary based

	on the nature of the services provided by the third-party provider.
Municipal (Include any municipal mandate that can be found within legislation)	
Federal	
Additional notes	

MONITORING & EVALUATION PLAN
If applicable, please describe the anticipated measurable outcomes and the data that will be used to track those outcomes. Include the section number(s) responsible for those outcomes

[] Check here if this proposal does NOT lead to any measurable outcomes

Section 1:

- Restitution: The amount of restitution ordered by the Insurance Commissioner in connection with Market Conduct examinations.
- Legal Action by the Insurance Commissioner: The amount of fines/penalties collected following legal action by the Insurance Commissioner.

ANYTHING ELSE WE SHOULD KNOW?

INSERT FULLY DRAFTED BILL HERE

Section 1. Section 38a-8 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The commissioner shall see that all laws respecting insurance companies and health care centers are faithfully executed and shall administer and enforce the provisions of this title. The commissioner shall have all powers specifically granted, and all further powers that are reasonable and necessary to enable the commissioner to protect the public interest in accordance with the duties imposed by this title, including the power to order restitution of any sums obtained in violation of any provision of this Title, any regulation or rule implementing the provisions of this Title or order issued by the Commissioner, plus interest at the rate set forth in section 37-3a. The commissioner shall pay to the Treasurer all the fees that the commissioner receives. The commissioner may administer oaths in the discharge of the commissioner's duties.

(b) The commissioner shall recommend to the General Assembly changes that, in the commissioner's opinion, should be made in the laws relating to insurance.

(c) In addition to the specific regulations that the commissioner is required to adopt, the commissioner may adopt such further regulations, in accordance with the provisions of chapter 54, as are reasonable and necessary to implement the provisions of this title.

(d) The commissioner shall develop a program of periodic review to ensure compliance by the Insurance Department with the minimum standards established by the National Association of Insurance Commissioners for effective financial surveillance and regulation of insurance companies operating in this state. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, pertaining to the financial surveillance and solvency regulation of insurance companies and health care centers as are reasonable and necessary to obtain or maintain the accreditation of the Insurance Department by the National Association of Insurance Commissioners. The commissioner shall maintain as confidential any confidential documents or information received from the National Association of Insurance Commissioners, or the International Association of Insurance Supervisors, or any documents or information received from state or federal insurance, banking or securities regulators or similar regulators in a foreign country that are confidential in such jurisdictions. The commissioner may share any information, including confidential information, with the National Association of Insurance Commissioners, the International Association of Insurance Supervisors, or state or federal insurance, banking or securities regulators or similar regulators in a foreign country, provided the commissioner determines that such entities agree to maintain the same level of confidentiality in their jurisdictions as is available in this state. At the expense of a domestic, alien or foreign insurer, the commissioner may engage the services of attorneys, actuaries, accountants and other experts not otherwise part of the commissioner's staff as may be necessary to assist the commissioner in the financial analysis of the insurer, the review of the insurer's license applications, and the review of transactions within a holding company system involving an insurer domiciled in this state. No duties of a person employed by the Insurance Department on November 1, 2002, shall be performed by such attorney, actuary, accountant or expert.

(e) The commissioner shall establish a program to reduce costs and increase efficiency through the use of electronic methods to transmit documents, including policy form and rate filings, to and from insurers and the Insurance Department. The commissioner may sit as a member of the board of a consortium organized

by or in association with the National Association of Insurance Commissioners for the purpose of coordinating a system for electronic rate and form filing among state insurance departments and insurers.

(f) The commissioner shall maintain as confidential information obtained, collected or prepared in connection with examinations, inspections or investigations, and complaints from the public received by the Insurance Department, if such records are protected from disclosure under federal law or state statute or, in the opinion of the commissioner, such records would disclose, or would reasonably lead to the disclosure of: (1) Investigative information the disclosure of which would be prejudicial to such investigation, until such time as the investigation is concluded; or (2) personal, financial or medical information concerning a person who has filed a complaint or inquiry with the Insurance Department, without the written consent of the person or persons to whom the information pertains.

(g) The commissioner may, in the commissioner's discretion, engage the services of such third-party actuaries, professionals and specialists that the commissioner deems necessary to assist the commissioner in reviewing any rate, form or similar filing submitted to the commissioner pursuant to this title. The cost of such services shall be borne by the person who submitted such rate, form or similar filing to the commissioner.

(h)(NEW) Whenever it appears to the commissioner that any person has violated, is violating or is about to violate of any provision of this Title, any regulation or rule implementing the provisions of this Title or order issued by the commissioner, the commissioner may or may authorize the Attorney General on his or her behalf, in the commissioner's discretion and in addition to any other remedy authorized by law: (1) bring an action in the superior court for the judicial district of Hartford to enjoin the acts or practices and to enforce compliance with any such provision, regulation, rule or order. Upon a proper showing, a permanent or temporary injunction, restraining order or writ of mandamus shall be granted. The court shall not require the commissioner to post a bond; (2) seek a court order imposing a penalty not to exceed one hundred thousand dollars per violation against any such person found to have violated any such provision, regulation, rule or order; or (3) apply to the superior court for the judicial district of Hartford for an order of restitution whereby such person shall be ordered to make restitution of any sums shown by the commissioner to have been obtained by such person in violation of any such provision, regulation, rule or order, plus interest at the rate set forth in section 37-3a. Whenever the commissioner prevails in any action brought under this subsection, the court may allow to the state its costs.

Section 2. Section 38a-16 of the general statutes is repealed and the following is substituted in lieu thereof:

(a)(1) The Insurance Commissioner or the commissioner's authorized representative may, as often as the commissioner deems necessary, conduct investigations and hearings in aid of any investigation on any matter under the provisions of this title. Pursuant to any such investigation or hearing, the commissioner or the commissioner's authorized representative may issue data calls, subpoenas, administer oaths, compel testimony, order the production of books, records, papers and documents, and examine books and records. Any person in receipt of such request shall comply with the request not later than thirty calendar days after the issuance of the request. If any person refuses to allow the examination of books and records, to appear, to testify or to produce any book, record, paper or document when so ordered, a judge of the Superior Court, upon application of the commissioner or the commissioner's authorized representative, may make such order as may be appropriate to aid in the enforcement of this section.

(2) Data provided in response to a data call under this section shall not be subject to disclosure under section 1-210.

(b) The Attorney General, at the request of the commissioner, is authorized to apply in the name of the state of Connecticut to the Superior Court for an order temporarily or permanently restraining and enjoining any person from violating any provision of this title.

Section 3. Section 38a-15(a) of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The commissioner shall, as often as the commissioner deems it expedient, undertake a market conduct examination of the affairs of (i) any insurance company, health care center, third-party administrator, as defined in section 38a-720, [or] fraternal benefit society doing business in this state, or (ii) any third-party providing administrative, substantive or other services, including collecting or providing data or data models, to an insurance company, health care center or fraternal benefit society doing business in this state. Any such examination may be conducted in accordance with the procedures and definitions set forth in the National Association of Insurance Commissioners' Market Regulation Handbook.

(b) To carry out the examinations under this section, the commissioner may appoint, as market conduct examiners, one or more competent persons, who shall not be officers of, or connected with or interested in, any insurance company, health care center, third-party administrator or fraternal benefit society, other than as a policyholder. In conducting the examination, the commissioner, the commissioner's actuary or any examiner authorized by the commissioner may examine, under oath, the officers and agents of such insurance company, health care center, third-party administrator or fraternal benefit society and all persons deemed to have material information regarding the company's, center's, administrator's or society's property or business. Each such company, center, administrator or society, its officers and agents, shall produce the books and papers, in its or their possession, relating to its business or affairs, and any other person may be required to produce any book or paper in such person's custody, deemed to be relevant to the examination, for the inspection of the commissioner, the commissioner's actuary or examiners, when required. The officers and agents of the company, center, administrator or society shall facilitate the examination and aid the examiners in making the same so far as it is in their power to do so.

(c) Each market conduct examiner shall make a full and true report of each market conduct examination made by such examiner, which shall comprise only facts appearing upon the books, papers, records or documents of the examined company, center, administrator or society or ascertained from the sworn testimony of its officers or agents or of other persons examined under oath concerning its affairs. The examiner's report shall be presumptive evidence of the facts therein stated in any action or proceeding in the name of the state against the company, center, administrator or society, its officers or agents. The commissioner shall grant a hearing to the company, center, administrator or society examined before filing any such report and may withhold any such report from public inspection for such time as the commissioner deems proper. The commissioner may, if the commissioner deems it in the public interest, publish any such report, or the result of any such examination contained therein, in one or more newspapers of the state.

(d) (1) All the expense of any examination made under the authority of this section, other than examinations of domestic insurance companies and domestic health care centers, shall be paid by the company, center, administrator or society examined. (2) No domestic insurance company or domestic health care center subject to an examination under this section shall pay as costs associated with the examination the salaries, fringe benefits or travel and maintenance expenses of examining personnel of the Insurance Department engaged in such examination if such domestic insurance company or domestic health care center is otherwise liable to assessment levied under section 38a-47, except that domestic insurance companies and domestic health care centers examined outside the state shall pay the travel and maintenance expenses of such examining personnel.

(e) (1) No cause of action shall arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representative or any examiner appointed or engaged by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this section. (2) No cause of action shall arise nor shall any liability be imposed against any person for the act of communicating or delivering information or data pursuant to an examination made under the authority of this section to the commissioner, the commissioner's authorized representative or an examiner if such communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive. (3) The provisions of this subsection shall not abrogate or modify any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subdivision (1) of this subsection.

(f) Nothing in this section shall be construed to prevent or prohibit the commissioner from disclosing at any time the content or results of an examination report or a preliminary examination report or any matter relating to such report, to (1) the insurance regulatory officials of this state or any other state or country, (2) law enforcement officials of this or any other state, or (3) any agency of this or any other state or of the federal government, provided such officials or agency receiving the report or matters relating to the report agrees, in writing, to hold such report or matters confidential.

(g) All workpapers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the commissioner or any other person in the course of an examination made under the authority of this section shall be confidential, shall not be subject to subpoena and shall not be made public by the commissioner or any other person, except to the extent provided in subsection (f) of this section. The commissioner may grant access to such workpapers, recorded information, documents and copies to the National Association of Insurance Commissioners, provided said association agrees, in writing, to hold such workpapers, recorded information, documents and copies thereof confidential.

Section 4. Section 38a-790 of the general statutes are repealed and the following is substituted in lieu thereof:

(a) No person shall act as an appraiser for motor vehicle physical damage claims on behalf of any insurance company or firm or corporation engaged in the adjustment or appraisal of motor vehicle claims unless such person has first secured a license from the Insurance Commissioner, and has paid the license fee specified in section 38a-11, for each two-year period or fraction thereof. The license shall be applied for as provided in section 38a-769. The commissioner may waive the requirement for examination in the case of any applicant for a motor vehicle physical damage appraiser's license who is a nonresident of this state and who holds an equivalent license from any other state. [Any such license issued by the

commissioner shall be in force until the thirtieth day of June in each odd-numbered year] Any initial license issued to a motor vehicle physical damage appraiser shall expire two years after the date of the licensee's birthday that preceded the date the license was issued unless sooner revoked or suspended. The license may, in the discretion of the commissioner, be renewed biennially upon payment of the fee specified in section 38a-11. The commissioner may adopt reasonable regulations concerning standards for qualification, suspension or revocation of such licenses and the methods by which licensees shall conduct their business.

(b) Any person who violates any provision of this section shall be fined not more than two thousand five hundred dollars or imprisoned not more than one year, or both.

(c) Any person who has been engaged in the business of motor vehicle physical damage appraising for a period of two consecutive years immediately prior to July 1, 1968, shall be granted a license upon application with no further qualifications. The commissioner may waive the examination required under section 38a-769, in the case of an applicant who at any time within two years next preceding the date of application has been licensed in this state under a license of the same type as the license applied for.

(d) For purposes of this section and section 38a-769:
(1) "Motor vehicle" has the same meaning as provided in section 14-1;
(2) "Motor vehicle physical damage appraiser" means any person, partnership, association, limited liability company or corporation that practices as a business the appraising of damages to motor vehicles insured under automobile physical damage policies or on behalf of third party claimants.

Section 5. Section 38a-792 of the general statutes are repealed and the following is substituted in lieu thereof:

(a)(1) No person may act as an adjuster of casualty claims for any insurance company or firm or corporation engaged in the adjustment of casualty claims unless such person has first secured a license from the commissioner, and has paid the license fee specified in section 38a-11, for each two-year period or fraction thereof. Application for such license shall be made as provided in section 38a-769. [Any such license issued by the commissioner shall be in force until June thirtieth in each odd-numbered year] Any initial license issued to a casualty adjuster shall expire two years after the date of the licensee's birthday that preceded the date the license was issued unless sooner revoked or suspended. The [person] licensee may, at the discretion of the commissioner, renew the license biennially thereafter upon payment of the fee specified in section 38a-11. (2) The commissioner may waive the examination required under section 38a-769, in the case of any applicant for a casualty claims adjuster's license that (A) is a nonresident of this state or has its principal place of business in another state, and holds an equivalent license from any other state, or (B) at any time within two years next preceding the date of application has been licensed in this state under a license of the same type as the license applied for.

(b) The commissioner may prescribe reasonable regulations, in accordance with the provisions of chapter 54, governing the licensing of casualty claims adjusters and the adjustment of casualty claims.

(c) Any person who violates any provision of this section shall be fined not more than two thousand dollars or imprisoned not more than one year or both.

(d) The provisions of this section shall not apply to any: (1) (A) Individual who, for purposes of claims for portable electronics insurance, as defined in section 38a-397, only (i) collects claim information from or furnishes claim information to insureds or claimants, and (ii) conducts data entry, including data entry into an automated claims adjudication system, provided (I) such individual is an employee of a casualty insurance company licensed in this state, an employee of a casualty claims adjuster licensed in this state or an employee of an affiliate of such insurance company or adjuster, and (II) not more than twenty-five such individuals are under the supervision of a casualty claims adjuster licensed in this state or an insurance producer who adjusts portable electronics insurance claims and is licensed in this state. A licensed insurance producer who adjusts portable electronics insurance claims or supervises individuals pursuant to this subparagraph shall not be required to be licensed as a casualty claims adjuster. (B) For purposes of this subdivision, "automated claims adjudication system" means a preprogrammed computer system, designed for the collection, data entry, calculation and final resolution of portable electronics insurance claims, that (i) is used only by a supervised individual, a casualty claims adjuster licensed in this state or an insurance producer licensed in this state, in accordance with subparagraph (A) of this subdivision, and (ii) complies with all applicable claims payment requirements under this title; or (2) Member of the bar of this state in good standing who is engaged in the general practice of the law.

Document Name	**CID - Technical Changes [2 of 3]**

Naming Format: AGENCY ACRONYM PROPOSAL NUMBER - TOPIC
Please insert a copy of the fully drafted bill at the end of this document (required for review)

Legislative Liaison	**Jim Carson**
Division Requesting This Proposal	**Financial Regulation** **Life & Health** **Business Office**
Drafter	**Anthony Francini** **Jennifer Dowty** **Michael Dandini** **Jane Callanan**

Title of Proposal	AAC Insurance Department Technical Changes
Statutory Reference, if any	38a-47; 38a-48; 38a-53; 38a-54; 38a-297; 38a-556; 38a-556a; 38a-503f; 38a-530f; 38a-564; 38a-614;
Brief Summary and Statement of Purpose	This technical change proposal will increase efficiencies and improve consistency by cleaning up sections of state statute consistent with our mission of effectively regulating the marketplace and also being easier to do business with. Eliminates the need for paper filings and permits all required filings to be submitted electronically. Repeals obsolete provisions. Establishes authority for existing insurance fund allocations.

SECTION-BY-SECTION SUMMARY
Summarize sections in groups where appropriate

Section 1. Adds to the Insurance Fund calculation the amounts appropriated to the newly formed Office of Behavioral Health Advocate.

Section 2. Amends the language to include the newly established Office of Behavioral Health Advocate, and to provide that the Insurance Commissioner will manage the Insurance Fund administration on behalf of all agencies that are supported by the Insurance Fund. Eliminates provisions applicable to the assessment process prior to July 1, 1990.

Section 3. Removes the paper filing requirement for domestic companies' annual reports and financial statements, and permits the electronic submission of such reports to the NAIC to satisfy the Department's filing requirement.

Section 4. Removes the paper filing requirement for domestic companies' audited reports and permits the electronic submission of such reports to the NAIC to satisfy the Department's filing requirement.

Section 5. Acknowledges that non-English policy forms may be used in Connecticut and requires that non-English forms comply with reading ease test requirement. Permits the Insurance Department to have the policy translated into English either by the insurer or at the cost of the insurer, and allows for the adoption of any corresponding regulations.

Section 6. Consistent with Section 9 below, removes from Conn. Gen. Stat. §38a-566 all references to Conn. Gen. Stat. §38a-556a.

Section 7. Repeals Conn. Gen. Stat. §38a-556a in full, removing the requirement for health reinsurance pool website "Connecticut Clearinghouse", which has become obsolete as the Health Reinsurance Association no longer has any covered lives and is no longer the issuer of last resort since the Affordable Care Act was enacted.

Section 8. Reverts definition of small employer back to 50 employees as permitted under the Affordable Care Act, which is consistent with the current application.

Section 9. Removes the paper filing requirement for domestic societies' annual reports and permits the electronic submission of such reports to the NAIC to satisfy the Department's filing requirement.

Section 10. Extends the approval or reapproval period for independent review organizations from two years to three years.

BACKGROUND

Origin of Proposal **[X] New Proposal** **[ ] Resubmission**

If this is a resubmission, please share the prior bill number, the reason the bill did not move forward, and any changes made or conversations had since it was last proposed:

Please consider the following, if applicable:

How does this proposal connect to the 10-year vision for the agency's mission?	The intention of our proposal is to protect policyholders.
How will we measure if the proposal successfully accomplishes its goals?	This is a technical change bill.
Have there been changes in federal/state laws or regulations that make this legislation necessary?	Yes. Section 1: Connecticut PA 23-101 created the Office of Behavioral Health Advocate (OBHA), which is within the Insurance Department for administrative purposes only. This necessitates amendments to Conn. Gen. Stat. §§38-47 and 48 to include OBHA in the insurance fund assessment and allocation authority.
Has this proposal or a similar proposal been implemented in other states? If yes, to what result?	No.
Have certain constituencies called for this proposal?	Sections 3 & 4: During the pandemic, insurance companies were granted permission to submit electronic annual financial statements. Sections 1-3 propose to codify the accommodation granted during this period.

	The remaining proposals are technical changes to the Insurance Law identified by Insurance Department staff.

INTERAGENCY IMPACT
List each affected agency. Copy the table as needed.

[x] Check here if this proposal does NOT impact other agencies

1. Agency Name	
Agency Contact (name, title)	
Date Contacted	
Status	**[ ] Approved [ ] Talks Ongoing**
Open Issues, if any	

FISCAL IMPACT
Include the section number(s) responsible for the fiscal impact and the anticipated impact

[X] Check here if this proposal does NOT have a fiscal impact

State	
Municipal (Include any municipal mandate that can be found within legislation)	
Federal	
Additional notes	

MONITORING & EVALUATION PLAN
If applicable, please describe the anticipated measurable outcomes and the data that will be used to track those outcomes. Include the section number(s) responsible for those outcomes

[X] Check here if this proposal does NOT lead to any measurable outcomes

ANYTHING ELSE WE SHOULD KNOW?

Section 1. 38a-47

(a) All domestic insurance companies and other domestic entities subject to taxation under chapter 207 shall, in accordance with section 38a-48, annually pay to the Insurance Commissioner, for deposit in the Insurance Fund established under section 38a-52a, an amount equal to:

(1) The actual expenditures made by the Insurance Department, the Office of Healthcare Advocate and Office of Behavioral Health Advocate during each fiscal year, [and the actual expenditures made by the Office of the Healthcare Advocate,] including the cost of fringe benefits for department and office personnel as estimated by the Comptroller;

(2) The amount appropriated to the Office of Health Strategy from the Insurance Fund for the fiscal year, including the cost of fringe benefits for office personnel as estimated by the Comptroller, which shall be reduced by the amount of federal reimbursement received for allowable Medicaid administrative expenses;

(3) The expenditures made on behalf of the department and said offices from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year, but excluding such estimated expenditures made on behalf of the Health Systems Planning Unit of the Office of Health Strategy; and

(4) The amount appropriated to the Department of Aging and Disability Services for the fall prevention program established in section 17a-859 from the Insurance Fund for the fiscal year.

(b) The expenditures and amounts specified in subdivisions (1) to (4), inclusive, of subsection (a) of this section shall exclude expenditures paid for by fraternal benefit societies, foreign and alien insurance companies and other foreign and alien entities under sections 38a-49 and 38a-50.

(c) Payments shall be made by assessment of all such domestic insurance companies and other domestic entities calculated and collected in accordance with the provisions of section 38a-48. Any such domestic insurance company or other domestic entity aggrieved because of any assessment levied under this section may appeal therefrom in accordance with the provisions of section 38a-52.

Section 2. 38a-48

(a) On or before June thirtieth, annually, the Commissioner of Revenue Services shall render to the Insurance Commissioner a statement certifying the amount of taxes or charges imposed on each domestic insurance company or other domestic entity under chapter 207 on business done in this state during the preceding calendar year. The statement for local domestic insurance companies shall set forth the amount of taxes and charges before any tax credits allowed as provided in subsection (a) of section 12-202.

(b) On or before July thirty-first, annually, the Insurance Commissioner [and the Office of the Healthcare Advocate] shall render to each domestic insurance company or other domestic entity liable for payment under section 38a-47: (1) A statement that includes (A) the amount appropriated to the Insurance Department, the Office of the Healthcare Advocate, the Office of Behavioral Health Advocate and the Office of Health Strategy from the Insurance Fund established under section 38a-52a for the fiscal year beginning July first of the same year, (B) the cost of fringe benefits for department and office personnel for such year, as estimated by the Comptroller, (C) the estimated expenditures on behalf of the department and the offices from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year, not including such estimated expenditures made on behalf of the Health Systems Planning Unit of the Office of Health Strategy, and (D) the amount appropriated to the Department of Aging and Disability Services for the fall prevention program established in section 17a-859 from the Insurance Fund

for the fiscal year; (2) a statement of the total taxes imposed on all domestic insurance companies and domestic insurance entities under chapter 207 on business done in this state during the preceding calendar year; and (3) the proposed assessment against that company or entity, calculated in accordance with the provisions of subsection (c) of this section, provided for the purposes of this calculation the amount appropriated to the Insurance Department, the Office of the Healthcare Advocate, the Office of Behavioral Health Advocate and the Office of Health Strategy from the Insurance Fund plus the cost of fringe benefits for department and office personnel and the estimated expenditures on behalf of the department and the office from the Capital Equipment Purchase Fund pursuant to section 4a-9, not including such expenditures made on behalf of the Health Systems Planning Unit of the Office of Health Strategy shall be deemed to be the actual expenditures of the department and the office, and the amounts appropriated to the Department of Aging and Disability Services from the Insurance Fund for the fiscal year for the fall prevention program established in section 17a-859 shall be deemed to be the actual expenditures for the program.

(c) (1) The proposed assessments for each domestic insurance company or other domestic entity shall be calculated by (A) allocating twenty per cent of the amount to be paid under section 38a-47 among the domestic entities organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, in proportion to their respective shares of the total taxes and charges imposed under chapter 207 on such entities on business done in this state during the preceding calendar year, and (B) allocating eighty per cent of the amount to be paid under section 38a-47 among all domestic insurance companies and domestic entities other than those organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, in proportion to their respective shares of the total taxes and charges imposed under chapter 207 on such domestic insurance companies and domestic entities on business done in this state during the preceding calendar year, provided if there are no domestic entities organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, at the time of assessment, one hundred per cent of the amount to be paid under section 38a-47 shall be allocated among such domestic insurance companies and domestic entities. (2) When the amount any such company or entity is assessed pursuant to this section exceeds twenty-five per cent of the actual expenditures of the Insurance Department, the Office of the Healthcare Advocate, Office of Behavioral Health Advocate and the Office of Health Strategy from the Insurance Fund, such excess amount shall not be paid by such company or entity but rather shall be assessed against and paid by all other such companies and entities in proportion to their respective shares of the total taxes and charges imposed under chapter 207 on business done in this state during the preceding calendar year, except that for purposes of any assessment made to fund payments to the Department of Public Health to purchase vaccines, such company or entity shall be responsible for its share of the costs, notwithstanding whether its assessment exceeds twenty-five per cent of the actual expenditures of the Insurance Department, the Office of the Healthcare Advocate, Office of Behavioral Health Advocate and the Office of Health Strategy from the Insurance Fund. The provisions of this subdivision shall not be applicable to any corporation which has converted to a domestic mutual insurance company pursuant to section 38a-155 upon the effective date of any public act which amends

said section to modify or remove any restriction on the business such a company may engage in, for purposes of any assessment due from such company on and after such effective date.

(d) For purposes of calculating the amount of payment under section 38a-47, as well as the amount of the assessments under this section, the "total taxes imposed on all domestic insurance companies and other domestic entities under chapter 207" shall be based upon the amounts shown as payable to the state for the calendar year on the returns filed with the Commissioner of Revenue Services pursuant to chapter 207; with respect to calculating the amount of payment and assessment for local domestic insurance companies, the amount used shall be the taxes and charges imposed before any tax credits allowed as provided in subsection (a) of section 12-202.

(e) [On or before September thirtieth, annually, for each fiscal year ending prior to July 1, 1990, the Insurance Commissioner and the Healthcare Advocate, after receiving any objections to the proposed assessments and making such adjustments as in their opinion may be indicated, shall assess each such domestic insurance company or other domestic entity an amount equal to its proposed assessment as so adjusted. Each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner on or before October thirty-first an amount equal to fifty per cent of its assessment adjusted to reflect any credit or amount due from the preceding fiscal year as determined by the commissioner under subsection (g) of this section. Each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner on or before the following April thirtieth, the remaining fifty per cent of its assessment.]

[(f)] On or before September first annually, for each fiscal year [ending after July 1, 1990,] the Insurance Commissioner [and the Healthcare Advocate], after receiving any objections to the proposed assessments and making such adjustments as in [their] the Insurance Commissioner's opinion may be indicated, shall assess each such domestic insurance company or other domestic entity an amount equal to its proposed assessment as so adjusted. Each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner (1) [on or before June 30, 1990, and] on or before June thirtieth annually [thereafter], an estimated payment against its assessment for the following year equal to twenty-five per cent of its assessment for the fiscal year ending such June thirtieth, (2) on or before September thirtieth, annually, twenty-five per cent of its assessment adjusted to reflect any credit or amount due from the preceding fiscal year as determined by the commissioner under subsection ([g]f) of this section, and (3) on or before the following December thirty-first and March thirty-first, annually, each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner the remaining fifty per cent of its proposed assessment to the department in two equal installments.

([g]f) If the actual expenditures for the fall prevention program established in section 17a-859 are less than the amount allocated, the Commissioner of Aging and Disability Services shall notify the Insurance Commissioner [and the Healthcare Advocate]. Immediately following the

close of the fiscal year, the Insurance Commissioner [and the Healthcare Advocate] shall recalculate the proposed assessment for each domestic insurance company or other domestic entity in accordance with subsection (c) of this section using the actual expenditures made during the fiscal year by the Insurance Department, the Office of the Healthcare Advocate, Office of Behavioral Health Advocate and the Office of Health Strategy from the Insurance Fund, the actual expenditures made on behalf of the department and the offices from the Capital Equipment Purchase Fund pursuant to section 4a-9, not including such expenditures made on behalf of the Health Systems Planning Unit of the Office of Health Strategy, and the actual expenditures for the fall prevention program. On or before July thirty-first annually, the Insurance Commissioner [and the Healthcare Advocate] shall render to each such domestic insurance company and other domestic entity a statement showing the difference between their respective recalculated assessments and the amount they have previously paid. On or before August thirty-first, the Insurance Commissioner [and the Healthcare Advocate], after receiving any objections to such statements, shall make such adjustments which in their opinion may be indicated, and shall render an adjusted assessment, if any, to the affected companies. Any such domestic insurance company or other domestic entity may pay to the Insurance Commissioner the entire assessment required under this subsection in one payment when the first installment of such assessment is due.

([h]g) If any assessment is not paid when due, a penalty of twenty-five dollars shall be added thereto, and interest at the rate of six per cent per annum shall be paid thereafter on such assessment and penalty.

([i]h) The Insurance Commissioner shall deposit all payments made under this section with the State Treasurer. On and after June 6, 1991, the moneys so deposited shall be credited to the Insurance Fund established under section 38a-52a and shall be accounted for as expenses recovered from insurance companies.

Section 3.

Sec. 38a-53. (Formerly Sec. 38-24).

(a)(1) Each domestic insurance company or domestic health care center shall, annually, on or before the first day of March, submit to the commissioner, by [and] electronically filing with [to] the National Association of Insurance Commissioners, a true and complete report, signed and sworn to by its president or a vice president, and secretary or an assistant secretary, of its financial condition on the thirty-first day of December next preceding, prepared in accordance with the National Association of Insurance Commissioners annual statement instructions handbook and following those accounting procedures and practices prescribed by the National Association of Insurance Commissioners accounting practices and procedures manual, subject to any deviations in form and detail as may be prescribed by the commissioner. An

electronically filed report in accordance with section 38a-53a that is timely submitted to the National Association of Insurance Commissioners shall [not] be deemed to have been submitted to the commissioner in accordance with this section [exempt a domestic insurance company or domestic health care center from timely filing a true and complete paper copy with the commissioner].

(2) Each accredited reinsurer, as defined in subdivision (1) of subsection (c) of section 38a-85, and assuming insurance company, as provided in section 38a-85, shall file an annual report in accordance with the provisions of section 38a-85.

(b) Each foreign insurance company or foreign health care center doing business in this state shall, annually, on or before the first day of March, submit to the commissioner, by electronically filing with the National Association of Insurance Commissioners, a true and complete report, signed and sworn to by its president or a vice president, and secretary or an assistant secretary, of its financial condition on the thirty-first day of December next preceding, prepared in accordance with the National Association of Insurance Commissioners annual statement instructions handbook and following those accounting procedures and practices prescribed by the National Association of Insurance Commissioners accounting practices and procedures manual, subject to any deviations in form and detail as may be prescribed by the commissioner. An electronically filed report in accordance with section 38a-53a that is timely submitted to the National Association of Commissioners shall be deemed to have been submitted to the commissioner in accordance with this section.

(c) In addition to such annual report, the commissioner, when the commissioner deems it necessary, may require any insurance company or health care center doing business in this state to file financial statements on a quarterly basis. An electronically filed true and complete report filed in accordance with section 38a-53a that is timely filed with the National Association of Insurance Commissioners shall be deemed to have been submitted to the commissioner in accordance with the provisions of this section.

(d) In addition to such annual report and the quarterly report required under subsection (c) of this section, the commissioner, whenever the commissioner determines that more frequent reports are required because of certain factors or trends affecting companies writing a particular class or classes of business or because of changes in the company's management or financial or operating condition, may require any insurance company or health care center doing business in this state to file financial statements on other than an annual or quarterly basis.

(e) Any insurance company or health care center doing business in this state that fails to file any report or statement required under this section shall pay a late filing fee of one hundred seventy-five dollars per day for each day from the due date of such report or statement to the date of filing. The commissioner may extend the due date of any report or statement required

under this section (1) if the insurance company or health care center cannot file such report or statement because the governor of such company's or center's state of domicile has proclaimed a state of emergency in such state and such state of emergency impairs the company's or center's ability to file the report or statement, (2) if the insurance regulatory official of the state of domicile of a foreign insurance company has permitted such company to file such report or statement late, or (3) for a domestic insurance company or a domestic health care center, for good cause shown.

(f) Each insurance company or health care center doing business in this state shall include in all reports required to be filed with the commissioner under this section a certification by an actuary or reserve specialist of all reserve liabilities prepared in accordance with regulations that shall be adopted by the commissioner in accordance with chapter 54. The regulations shall: (1) Specify the contents and scope of the certification; (2) provide for the availability to the commissioner of the workpapers of the actuary or loss reserve specialist; and (3) provide for granting companies or centers exemptions from compliance with the requirements of this subsection. The commissioner shall maintain, as confidential, all workpapers of the actuary or loss reserve specialist and the actuarial report and actuarial opinion summary provided in support of the certification. Such workpapers, reports and summaries shall not be subject to subpoena or disclosure under the Freedom of Information Act, as defined in section 1-200.

Section 4.

Sec. 38a-54.

(a) Each domestic insurance company, domestic health care center or domestic fraternal benefit society doing business in this state shall have an annual audit conducted by an independent certified public accountant and shall annually file an audited financial report with the commissioner, and electronically to the National Association of Insurance Commissioners on or before the first day of June for the year ending the preceding December thirty-first. An electronically filed true and complete report timely submitted to the National Association of Insurance Commissioners be deemed to have been submitted to the commissioner in accordance with this section. [does not exempt a domestic insurance company or a domestic health care center from timely filing a true and complete paper copy to the commissioner.]

(b) Each foreign insurance company, foreign health care center or foreign fraternal benefit society doing business in this state shall have an annual audit conducted by an independent certified public accountant and shall annually file an audited financial report with the commissioner, and electronically to the National Association of Insurance Commissioners, on or before June first for the year ending the preceding December thirty-first. An electronically filed true and complete report timely submitted to the National Association of Insurance Commissioners shall be deemed to have been submitted to the commissioner in accordance with the provisions of this section.

(c) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 to: (1) Specify the scope of the examination required by this section; (2) specify the contents and scope of the annual audited financial report, provided such report shall include all incurred losses; (3) provide for the review of the controls; (4) provide for the availability to the commissioner of the workpapers of the certified public accountant; and (5) provide exemptions from compliance with the requirements of this section.

Section 5. § 38a-297.

(a) For the purposes of sections 38a-295 to 38a-300, inclusive, a policy shall be deemed readable if: (1) The text achieves a minimum score of forty-five on the Flesch reading ease test as computed in section 38a-298 or an equivalent score on any other test comparable in result and approved by the commissioner, (2) it is printed, except for specification pages, schedules and tables, in not less than ten-point type, one-point leaded, of a height and style specified by the commissioner in regulations adopted in accordance with the provisions of chapter 54,1 (3) it uses layout and spacing which separate the paragraphs from each other and from the border of the paper, (4) it has section titles captioned in boldface type or which otherwise stand out significantly from the text, (5) it avoids the use of unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions, (6) the style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsements or riders and (7) it contains a table of contents or an index of the principal sections of the policy, if the policy has more than three thousand words or if the policy has more than three pages. To be deemed readable, each policy of individual health insurance shall include a separate outline of coverage showing the major coverage, benefit, exclusion and renewal provisions of the policy in readily understandable terms, provided the policy shall take precedence over the outline of coverage.

(b) The commissioner may authorize a lower score than the Flesch reading ease score required in subsection (a) whenever he finds that a lower score (1) will provide a more accurate reflection of the readability of a policy form; (2) is warranted by the nature of a particular policy form or type or class of policy forms; or (3) is the result of language which is used to conform to the requirements of any state or federal law, regulation or governmental agency.

(c) Filings subject to this section shall be accompanied by a certification signed by an officer of the insurer stating that it meets the requirements of subsection (a) of this section. Such certification shall state that the policy meets the minimum reading ease score on the test used or that the score is lower than the minimum required but should be approved in accordance with subsection (b) of this section. The commissioner may require the submission of further information to verify any certification.

(d) This state permits the use of policies in any language. Any non-English-language policy shall be deemed to be in compliance with subsection (a) of this section if the insurer certifies that such policy [is translated from an English-language policy that] complies with [said] subsection (a) or is translated from a policy that complies with subsection (a).

(e) The commissioner may engage the services of translators or other professionals and specialists as needed to review filings under this section, the cost of which shall be borne by the insurer submitting each such filing.

(f) The commissioner may require any insurer that submits a non-English policy to either (i) provide a copy of the policy translated into English with a certification as to the accuracy of the translation, or (ii) pay all costs associated with the translation of the policy into English by the Insurance Department or its designee. The insurer shall bear all risk associated with the translation of its policy form to or from English whether such translation is performed by the insurer, the Insurance Department or the Insurance Department's designee.

(g) The commissioner may adopt regulations, in accordance with the provisions of chapter 54 to implement the provisions of this section.

Section 6.

Sec. § 38a-556.

(a) There is hereby created a nonprofit legal entity to be known as the Health Reinsurance Association. All insurers, health care centers and self-insurers doing business in the state, as a condition to their authority to transact the applicable kinds of health insurance defined in section 38a-551, shall be members of the association. The association shall perform its functions under a plan of operation established and approved under subsection (b) of this section, and shall exercise its powers through a board of directors established under this section.

(b) (1) The board of directors of the association shall be made up of nine individuals selected by participating members, subject to approval by the commissioner, two of whom shall be appointed by the commissioner on or before July 1, 1993, to represent health care centers. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the net health insurance premium derived from this state in the previous calendar year. If the board of directors is not selected within sixty days after notice of the organizational meeting, the commissioner may

appoint the initial board. In approving or selecting members of the board, the commissioner may consider, among other things, whether all members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services.

(2) The board shall submit to the commissioner a plan of operation for the association necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation shall become effective upon approval in writing by the commissioner. Such plan shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner. The plan of operation shall: (A) Establish procedures for the handling and accounting of assets and moneys of the association; (B) establish regular times and places for meetings of the board of directors; (C) establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner; (D) establish procedures whereby selections for the board of directors shall be made and submitted to the commissioner; (E) establish procedures to amend, subject to the approval of the commissioner, the plan of operations; (F) establish procedures for the selection of an administrator and set forth the powers and duties of the administrator; (G) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and (H) contain additional provisions necessary for the association to establish health insurance plans that qualify as acceptable coverage in accordance with the Pension Benefit Guaranty Corporation and other state or federal programs that may be established.

(c) The association shall have the general powers and authority granted under the laws of this state to carriers to transact the kinds of insurance defined under section 38a-551, and in addition thereto, the specific authority to: (1) Enter into contracts necessary or proper to carry out the provisions and purposes of this section and sections 38a-551 and **[**38a-556a**]** 38a-557 to 38a-559, inclusive; (2) sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating members; (3) take such legal action as necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association; (4) establish, with respect to health insurance provided by or on behalf of the association, appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the operational expenses of the association; (5) administer any type of reinsurance program, for or on behalf of participating members; (6) pool risks among participating members; (7) issue policies of insurance required or permitted by this section and sections 38a-551 and **[**38a-556a**]** 38a-557 to 38a-559, inclusive, in its own name or on behalf of participating members; (8) administer separate pools, separate accounts or other plans as deemed appropriate for separate members or groups of members; (9) operate and administer

any combination of plans, pools, reinsurance arrangements or other mechanisms as deemed appropriate to best accomplish the fair and equitable operation of the association; (10) set limits on the amounts of reinsurance that may be ceded to the association by its members; (11) appoint from among participating members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association; (12) apply for and accept grants, gifts and bequests of funds from other states, federal and interstate agencies and independent authorities, private firms, individuals and foundations for the purpose of carrying out its responsibilities. Any such funds received shall be deposited in the General Fund and shall be credited to a separate nonlapsing account within the General Fund for the Health Reinsurance Association and may be used by the Health Reinsurance Association in the performance of its duties; and (13) perform such other duties and responsibilities as may be required by state or federal law or permitted by state or federal law and approved by the commissioner.

(d) Rates for coverage issued by or through the association shall not be excessive, inadequate or unfairly discriminatory. All rates shall be promulgated by the association through an actuarial committee consisting of five persons who are members of the American Academy of Actuaries, shall be filed with the commissioner and may be disapproved within sixty days after the filing thereof if excessive, inadequate or unfairly discriminatory.

(e) (1) Following the close of each fiscal year, the administrator shall determine the net premiums, reinsurance premiums less administrative expense allowance, the expense of administration pertaining to the reinsurance operations of the association and the incurred losses for the year. Any net loss shall be assessed to all participating members in proportion to their respective shares of the total health insurance premiums earned in this state during the calendar year, or with paid losses in the year, coinciding with or ending during the fiscal year of the association or on any other equitable basis as may be provided in the plan of operations. For self-insured members of the association, health insurance premiums earned shall be established by dividing the amount of paid health losses for the applicable period by eighty-five per cent. Net gains, if any, shall be held at interest to offset future losses or allocated to reduce future premiums.

(2) Any net loss to the association represented by the excess of its actual expenses of administering policies issued by the association over the applicable expense allowance shall be separately assessed to those participating members who do not elect to administer their plans. All assessments shall be on an equitable formula established by the board.

(3) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association and the association shall have an annual audit of its operations by an independent certified public accountant. The annual audit shall be filed with

the commissioner for his review and the association shall be subject to the provisions of section 38a-14.

(f) All policy forms issued by or through the association shall conform in substance to prototype forms developed by the association, shall in all other respects conform to the requirements of this section and sections 38a-551 and **[**38a-556a**]** 38a-557 to 38a-559, inclusive, and shall be approved by the commissioner. The commissioner may disapprove any such form if it contains a provision or provisions that are unfair or deceptive or that encourage misrepresentation of the policy.

(g) Unless otherwise permitted by the plan of operation, the association shall not issue, reissue or continue in force health care plan coverage with respect to any person who is already covered under an individual or group health care plan, or who is sixty-five years of age or older and eligible for Medicare or who is not a resident of this state.

(h) Benefits payable under a health care plan insured by or reinsured through the association shall be paid net of all other health insurance benefits paid or payable through any other source, and net of all health insurance coverages provided by or pursuant to any other state or federal law including Title XVIII of the Social Security Act,1 Medicare, but excluding Medicaid.

(i) There shall be no liability on the part of and no cause of action of any nature shall arise against any carrier or its agents or its employees, the Health Reinsurance Association or its agents or its employees or the residual market mechanism established under the provisions of section 38a-557 or its agents or its employees, or the commissioner or the commissioner's representatives for any action taken by them in the performance of their duties under this section and sections 38a-551 and **[**38a-556a**]** 38a-557 to 38a-559, inclusive. This provision shall not apply to the obligations of a carrier, a self-insurer, the Health Reinsurance Association or the residual market mechanism for payment of benefits provided under a health care plan.

Section 7. Section 38a-556a is repealed.

Section 8.

§ 38a-564.

As used in this section and sections 38a-566, 38a-567, 38a-569 and 38a-574:

(1) “Pool” means the Connecticut Small Employer Health Reinsurance Pool, established under section 38a-569.

(2) “Board” means the board of directors of the pool.

(3) “Employee” means an individual employed by an employer. “Employee” does not include

(A) an individual and such individual's spouse with respect to an incorporated or unincorporated trade or business that is wholly owned by such individual, by such individual's spouse or by such individual and such individual's spouse, or (B) a partner in a partnership and such partner's spouse with respect to such partnership.

(4) (A) “Small employer” means (i) prior to January 1, 2016, an employer that employed an average of at least one but not more than fifty employees on business days during the preceding calendar year and employs at least one employee on the first day of the group health insurance plan year, [and] (ii) on and after January 1, 2016, and prior to January 1, 2025, an employer that employed an average of at least one but not more than one hundred employees on business days during the preceding calendar year and employs at least one employee on the first day of the group health insurance plan year, **[**except the commissioner may postpone said

January 1, 2016, date to be consistent with any such postponement made by the Secretary of the United States Department of Health and Human Services under the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time.**]** and (iii) on and after January 1, 2025, an employer that employed an average of at least one but not more than fifty employees on business days during the preceding calendar year and employs at least one employee on the first day of the group health insurance plan year. "Small employer" does not include a sole proprietorship that employs only the sole proprietor or the spouse of such sole proprietor.

(B) (i) For purposes of subparagraph (A) of this subdivision, the number of employees shall be determined by adding (I) the number of full-time employees for each month who work a normal work week of thirty hours or more, and (II) the number of full-time equivalent employees, calculated for each month by dividing by one hundred twenty the aggregate number of hours worked for such month by employees who work a normal work week of less than thirty hours, and averaging such total for the calendar year.

(ii) If an employer was not in existence throughout the preceding calendar year, the number of employees shall be based on the average number of employees that such employer reasonably expects to employ in the current calendar year.

(C) All persons treated as a single employer under Section 414 of the Internal Revenue Code of 1986,1 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, shall be considered a single employer for purposes of this subdivision.

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

(6) "Insurance arrangement" means any multiple employer welfare arrangement, as defined in Section 3 of the Employee Retirement Income Security Act of 1974,2 as amended from time to time, except for any such arrangement that is fully insured within the meaning of Section 514(b)(6) of said act, as amended from time to time.

(7) "Health insurance plan" means any hospital and medical expense incurred policy, hospital or medical service plan contract and health care center subscriber contract. "Health insurance plan" does not include (A) accident only, credit, dental, vision, Medicare supplement, long-term care or disability insurance, hospital indemnity coverage, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payments insurance, or insurance under which beneficiaries are payable without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, or (B) policies of specified disease or limited benefit health insurance, provided the carrier offering such policies files on or before March first of each year

a certification with the commissioner that contains the following: (i) A statement from the carrier certifying that such policies are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance; (ii) a summary description of each such policy including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender or other factors, charged for such policies in the state; and (iii) in the case of a policy that is described in this subparagraph and that is offered for the first time in this state on or after October 1, 1993, the carrier files with the commissioner the information and statement required in this subparagraph at least thirty days prior to the date such policy is issued or delivered in this state.

(8) “Plan of operation” means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to section 38a-569.

(9) “Dependent” means the spouse or child of an eligible employee, subject to applicable terms of the health insurance plan covering such employee. “Dependent” includes any dependent who is covered under the small employer's health insurance plan pursuant to workers' compensation, continuation of benefits pursuant to section 38a-512a or other applicable laws.

(10) “Commissioner” means the Insurance Commissioner.

(11) “Member” means each insurer and insurance arrangement participating in the pool.

(12) “Small employer carrier” means any insurer or insurance arrangement that offers or maintains group health insurance plans covering eligible employees of one or more small employers.

(13) “Health care center” has the same meaning as provided in section 38a-175.

(14) “Case characteristics” means demographic or other objective characteristics of a small employer, including age and geographic location. “Case characteristics” does not include claims experience, health status or duration of coverage since issue.

Section 9.

Sec. 38a-614. (Formerly Sec. 38-237).

(1) Each domestic society transacting business in this state shall, annually, on or before the first day of March, unless the commissioner has extended such time for cause shown, file with the commissioner, and electronically to the National Association of Insurance Commissioners, a true and complete statement of its financial condition, transactions and affairs for the preceding calendar year and pay the fee specified in section 38a-11 for filing such annual

statement. The statement shall be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the commissioner. An electronically filed true and complete report filed in accordance with section 38a-53a that is timely submitted to the National Association of Insurance Commissioners shall be deemed to have been submitted to the commissioner in accordance with this section. [not exempt a domestic society from timely filing a true and complete paper copy with the commissioner.]

(2) Each foreign society transacting business in this state shall, annually, on or before the first day of March, unless the commissioner has extended such time for cause shown, file with the commissioner, and electronically to the National Association of Insurance Commissioners, a true and complete statement of its financial condition, transactions and affairs for the preceding calendar year and pay the fee specified in section 38a-11 for filing such annual statement. The statement shall be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the commissioner. An electronically filed true and complete report filed in accordance with section 38a-53a that is timely submitted to the National Association of Insurance Commissioners shall be deemed to have been submitted to the commissioner in accordance with this subsection.

(3) Not later than June first, annually, each society shall print and mail to each benefit member of the society a synopsis of its annual statement that provides an explanation of the facts thereby disclosed concerning the condition of the society. In lieu thereof, a society may publish such synopsis in the society's official publication.

(4) (A) As part of the annual statement required under this subsection, each society shall, annually, on or before the first day of March, file with the commissioner a valuation of its certificates in force on December thirty-first last preceding, provided the commissioner may, for cause shown, extend the time for filing such valuation for not more than two calendar months. Such report of valuation shall show, as reserve liabilities, the difference between the present midyear value of the promised benefits provided in the certificates of such society in force and the present midyear value of the future net premiums as the same are in practice actually collected, not including therein any value for the right to make extra assessments and not including any amount by which the present midyear value of future net premiums exceeds the present midyear value of promised benefits on individual certificates.

(B) At the option of any society, in lieu of the valuation specified in subparagraph (A) of this subdivision, the valuation may show the net tabular value. Such net tabular value as to certificates issued prior to January 1, 1959, shall be determined in accordance with the provisions of law applicable prior to January 1, 1958, and as to certificates issued on or after January 1, 1959, shall not be less than the reserves determined according to the Commissioners' Reserve Valuation method as hereinafter defined. If the premium charge is less

than the tabular net premium according to the basis of valuation used, an additional reserve equal to the present value of the deficiency in such premiums shall be set up and maintained as a liability. The reserve liabilities shall be properly adjusted if the midyear or tabular values are not appropriate.

(5) Reserves according to the Commissioners' Reserve Valuation method, for the life insurance and endowment benefits of certificates providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such certificates over the then present value of any future modified net premiums therefor. The modified net premiums for any such certificate shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the certificate, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the certificate and the excess of (A) over (B), as follows: (A) A net level premium equal to the present value, at the date of issue, of such benefits provided for after the first certificate year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such certificate on which a premium falls due; provided such net level annual premium shall not exceed the net level annual premium on the nineteen year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of such certificate; and (B) a net one-year term premium for such benefits provided for in the first certificate year. Reserves according to the Commissioners' Reserve Valuation method for (i) life insurance benefits for varying amounts of benefits or requiring the payment of varying premiums, (ii) annuity and pure endowment benefits, (iii) disability and accidental death benefits in all certificates and contracts, and (iv) all other benefits except life insurance and endowment benefits shall be calculated by a method consistent with the principles of this subdivision.

(6) The present value of deferred payments due under incurred claims or matured certificates shall be deemed a liability of the society and shall be computed upon mortality and interest standards prescribed in subdivision (7) of this subsection.

(7) Such valuation and underlying data shall be certified by a competent actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society. The minimum standards of valuation for certificates issued prior to January 1, 1959, shall be those provided by the law applicable immediately prior to January 1, 1958, but not lower than the standards used in the calculating of rates for such certificates. The minimum standard of valuation for certificates issued after January 1, 1959, shall be three and one-half per cent interest and the following tables: (A) For certificates of life insurance, American Men Ultimate Table of Mortality, with Bowerman's or Davis' Extension thereof or, with the consent of the Insurance Commissioner, the Commissioner's 1941 Standard Ordinary Mortality Table or the Commissioner's 1941 Standard Industrial Table of Mortality, or the

Commissioners' 1958 Standard Ordinary Mortality Table, except that, with the approval of the commissioner, the valuation of contracts on female risks may be calculated, at the option of the society, according to an age not more than three years younger than the actual age of the insured; (B) for annuity certificates, including life annuities provided or available under optional modes of settlement in such certificates, the 1937 Standard Annuity Table; (C) for disability benefits issued in connection with life benefit certificates, Hunter's Disability Table, which, for active lives, shall be combined with a mortality table permitted for calculating the reserves on life insurance certificates, except that the table known as Class III Disability Table (1926), modified to conform to the contractual waiting period, shall be used in computing reserves for disability benefits under a contract which presumes that total disability shall be considered to be permanent after a specified period; (D) for accidental death benefits issued in connection with life benefit certificates, the Inter-Company Double Indemnity Mortality Table combined with a mortality table permitted for calculating the reserves for life insurance certificates; and (E) for noncancellable accident and health benefits, the Class III Disability Table (1926) with conference modifications or, with the consent of the commissioner, tables based upon the society's own experience. The commissioner may accept other standards for valuation if the commissioner finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard herein prescribed. The commissioner may, in his or her discretion, vary the standards of mortality applicable to all certificates of insurance on substandard lives or other extra hazardous lives by any society authorized to do business in this state. Whenever the mortality experience under all certificates valued on the same mortality table is in excess of the expected mortality according to such table for a period of three consecutive years, the commissioner may require additional reserves when deemed necessary in the commissioner's judgment on account of such certificates. Any society, with the consent of the insurance commissioner of the state of domicile of the society and under such conditions, if any, that such commissioner may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any insured member shall not be affected thereby.

(8) A society doing business in this state that fails to file the annual statement in the form and within the time provided by this subsection shall pay a late filing fee of one hundred seventy-five dollars per day for each day from the due date of such statement, and, upon notice by the commissioner to that effect, its authority to do business in this state shall cease while such failure to file continues. The commissioner may waive the late filing fee if (A) the society cannot file such statement because the governor of such society's state of domicile has proclaimed a state of emergency in such state and such state of emergency impairs the society's ability to file the statement, or (B) the insurance regulatory official of the state of domicile of a foreign benefit society has permitted the society to file such statement late.

(9) Notwithstanding the provisions of this subsection, a society may, with the approval of the Insurance Commissioner, use the standards for valuation and nonforfeiture authorized by the

provisions of sections 38a-61, 38a-77, 38a-78, 38a-81, 38a-82, 38a-284, 38a-287, 38a-430 to 38a-454, inclusive, and 38a-458.

(b) Each association that is (1) a tax-exempt organization under Section 501(c)(23) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, (2) doing business in this state, and (3) not licensed under sections 38a-595 to 38a-626, inclusive, 38a-631 to 38a-640, inclusive, and 38a-800, shall, annually, on or before the first day of May, file with the commissioner a true and complete financial statement audited by an independent certified public accountant or accounting firm of its financial condition, transactions and affairs for the preceding calendar year and pay the fee specified in section 38a-11 for filing such annual statement.

Section 10.

Sec. 38a-591*ℓ*.

(a) (1) The commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews and expedited external reviews under section 38a-591g.

(2) The commissioner shall (A) develop an application form for the initial approval and for the reapproval of independent review organizations, and (B) maintain and periodically update a list of approved independent review organizations.

(b) (1) Any independent review organization seeking to conduct external reviews and expedited external reviews under section 38a-591g shall submit the application form for approval or reapproval, as applicable, to the commissioner and shall include all documentation and information necessary for the commissioner to determine if the independent review organization satisfies the minimum qualifications established under this section.

(2) An approval or reapproval shall be effective for three [two] years, unless the commissioner determines before the expiration of such approval or reapproval that the independent review organization no longer satisfies the minimum qualifications established under this section.

(3) Whenever the commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under this section, the commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of approved independent review organizations specified in subdivision (2) of subsection (a) of this section.

(c) To be eligible for approval by the commissioner, an independent review organization shall:

(1) Have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in section 38a-591g that include, at a minimum: (A) A quality assurance mechanism in place that ensures: (i) That external reviews and expedited external reviews are conducted within the specified time frames and required notices are provided in a timely manner; (ii) (I) The selection of qualified and impartial clinical peers to conduct such reviews on behalf of the independent review organization and the suitable matching of such peers to specific cases, and (II) the employment of or the contracting with an adequate number of clinical peers to meet this objective; (iii) The confidentiality of medical and treatment records and clinical review criteria; (iv) That any person employed by or under contract with the independent review organization adheres to the requirements of section 38a-591g; and (B) A toll-free telephone number to receive information twenty-four hours a day, seven days a week, related to external reviews and expedited external reviews and that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours;

(2) Agree to maintain and provide to the commissioner the information set forth in section 38a-591m;

(3) Not own or control, be a subsidiary of, be owned or controlled in any way by, or exercise control with a health benefit plan, a national, state or local trade association of health benefit plans, or a national, state or local trade association of health care professionals; and

(4) Assign as a clinical peer a health care professional who meets the following minimum qualifications: (A) Is an expert in the treatment of the covered person's medical condition that is the subject of the review; (B) Is knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person; (C) Holds a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the review; and (D) Has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit or regulatory body that raise a substantial question as to the clinical peer's physical, mental or professional competence or moral character.

(d) (1) An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the commissioner has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed to be in compliance with this section.

(2) The commissioner shall initially review and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether such entity's standards are, and continue to be, equivalent to or exceed the

minimum qualifications established under this section. The commissioner may accept a review conducted by the National Association of Insurance Commissioners for the purpose of the determination under this subdivision.

(3) Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the commissioner or the National Association of Insurance Commissioners in order for the commissioner to determine if such entity's standards are equivalent to or exceed the minimum qualifications established under this section. The commissioner may exclude any private accrediting entity that is not reviewed by the National Association of Insurance Commissioners.

Document Name	**CID - Captive Insurance [3 of 3]**

Naming Format: AGENCY ACRONYM PROPOSAL NUMBER - TOPIC
Please insert a copy of the fully drafted bill at the end of this document (required for review)

Legislative Liaison	Jim Carson
Division Requesting This Proposal	Captive
Drafter	Anthony Francini Fenhua Liu

Title of Proposal	An Act Concerning Captive Insurance
Statutory Reference, if any	
Brief Summary and Statement of Purpose	This proposal brings flexibility to captive insurance owners consistent with the Department's goals of being a captive domicile state of choice and keeps us competitive with other state's captive laws. New - Protected Cell Conversion – This proposal provides protected cells or incorporated protected cells with the ability to convert into a new protected cell, incorporated protected cell or captive insurance company. The purpose of this proposal is to allow businesses the flexibility that they require related to the use of a protected cell and to make the Connecticut captive laws more consistent with other top domiciles. This proposal provides an option for protected cells or incorporated protected cells to convert to a new captive insurance company, protected cell or incorporated protected cell without any impact on the assets, rights,

	benefits, obligations and liabilities of the protected cell or incorporated protected cell to be converted.

SECTION-BY-SECTION SUMMARY
Summarize sections in groups where appropriate

See above.

BACKGROUND

Origin of Proposal **[X] New Proposal** **[ ] Resubmission**

If this is a resubmission, please share the prior bill number, the reason the bill did not move forward, and any changes made or conversations had since it was last proposed: N/A

Please consider the following, if applicable:

How does this proposal connect to the 10-year vision for the agency's mission?	The intention of this proposal is to protect policyholders.
How will we measure if the proposal successfully accomplishes its goals?	Success will be measured by the increase in new captives domiciled in Connecticut.
Have there been changes in federal/state laws	No

or regulations that make this legislation necessary?	
Has this proposal or a similar proposal been implemented in other states? If yes, to what result?	Yes. The captive laws in other states (including Vermont and North Carolina) allow for the conversion of protected cells to the same extent provided by this proposal. This proposal will provide businesses that choose to use a protected cell formed in Connecticut the same ability to convert as provided by other top captive domiciles. Information regarding the number of protected cell conversions is not available from other states.
Have certain constituencies called for this proposal?	Yes. Captive Managers have asked for the ability convert protected cells.

INTERAGENCY IMPACT
List each affected agency. Copy the table as needed.

[X] Check here if this proposal does NOT impact other agencies

1. Agency Name	
Agency Contact (name, title)	
Date Contacted	
Status	**[ ] Approved [ ] Talks Ongoing**
Open Issues, if any	

FISCAL IMPACT
Include the section number(s) responsible for the fiscal impact and the anticipated impact

[ ] Check here if this proposal does NOT have a fiscal impact

State	With the addition of this proposal, Connecticut will be better positioned to attract more captive business. With additional Connecticut domiciled captives and as the result of a protected cell conversions, the state will realize additional taxes and fees revenue.
Municipal (Include any municipal mandate that can be found within legislation)	None
Federal	None
Additional notes	None

MONITORING & EVALUATION PLAN
If applicable, please describe the anticipated measurable outcomes and the data that will be used to track those outcomes. Include the section number(s) responsible for those outcomes

[ ] Check here if this proposal does NOT lead to any measurable outcomes

Measurable Outcomes:

1. Additional Connecticut Domiciled Captives:
    a. Businesses may choose to domicile a captive in Connecticut because of the ability to convert a protected cell as provided by this proposal.
    b. As a result of protected cell conversions, additional Connecticut domiciled captives may be formed.

ANYTHING ELSE WE SHOULD KNOW?

INSERT FULLY DRAFTED BILL HERE

[NEW] Protected cell conversion.

(a)(1) Subject to the prior written approval of the commissioner, upon application of the sponsor and with the prior written consent of each affected protected cell participant and each affected incorporated protected cell, a sponsored captive insurance company or a sponsored captive insurance company licensed as a special purpose financial captive insurance company may convert one or more protected cells or incorporated protected cells into a:

(A) single protected cell or incorporated protected cell;

(B) new sponsored captive insurance company;

(C) new sponsored captive insurance company licensed as a special purpose financial captive insurance company;

(D) new special purpose financial captive insurance company;

(E) new pure captive insurance company;

(F) new risk retention group;

(G) new agency captive insurance company;

(H) new industrial insured captive insurance company; or

(I) new association captive insurance company.

(2) Any such conversion shall be subject to the provisions of section 38a-91aa to 38a-91xx, inclusive, as applicable, as well as to a plan or plans of operation approved by the commissioner, without affecting any protected cell's or incorporated protected cell's assets, rights, benefits, obligations, and liabilities.

(b) Any such conversion shall be deemed for all purposes to be a continuation of each such protected cell's or incorporated protected cell's existence together with all of its assets, rights, benefits, obligations, and liabilities, as a new protected cell or incorporated protected cell, a sponsored captive insurance company, a sponsored captive insurance company licensed as a special purpose financial captive insurance company, a pure captive insurance company, a risk retention group, an industrial insured captive insurance company, or an association captive insurance company, as applicable. Any such conversion shall be deemed to occur without any transfer or assignment of any such assets, rights,

benefits, obligations, or liabilities and without the creation of any reversionary interest in, or impairment of, any such assets, rights, benefits, obligations, and liabilities.

(c) Any such conversion shall not be construed to limit any rights or protections applicable to any converted protected cell or incorporated protected cell and such sponsored captive insurance company or sponsored captive insurance company licensed as a special purpose financial captive insurance company, as applicable, that existed immediately prior to the date of any such conversion.

(d)(1) Any protected cell converting into an incorporated protected cell pursuant to this section, or converting into a new captive insurance company or risk retention group pursuant to this section, shall perform such conversion in accordance with:

(A) the provisions of chapter 601 if the converted entity is to be a corporation;

(B) the provisions of chapter 613A if the converted entity is to be a limited liability company; or

(C) the provisions applicable to any other type of entity permissible under Connecticut law if the converted entity is to be such an entity.