List of CID Bills by Priority:

	Document Name:
1. Standard Valuation Law & Standard Non-Forfeiture (SVL)	CID1101StandardValuationAndNonforfeiture.doc
2. Risk Management and Own Risk and Solvency Assessment Model Act (ORSA)	CID1101ORSA.doc
3. Adjustments to the Holding Company Act	CID1101HoldingCompanyAct.doc
4. Establishment of Connecticut as a Port of Entry for Non-U.S. Insurers	CID1101PortOfEntry.doc
5. Adjustments to Captive Statutes	CID1101Captives.doc
6. Financial Regulation of Insurers	CID1101FinancialRegulationsRevisions.doc
7. Changes to State Insurance Law to Conform to the Affordable Care Act	CID1101AffordableCareAct
8. Long Term Care Rate Increase Relief	CID1101LongTermCareHealthInsurance.doc
9. Market Conduct Authority	CID1101MarketConductAuthority.doc
10. Adjustments to CIGA and CLHIGA statutes	CID1101GuarantyAssociations.doc
11. Adjustments to the Bail Bond Statutes	CID1101BailBonds.doc
12. Third Party Administrator Annual Report	CID1101ThirdPartyAdministrator.doc

11/1/2013

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID1101StandardValuationAndNonforfeitureLaws.doc
(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Connecticut Insurance Department

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Lead agency division requesting this proposal:
Actuarial Division

Agency Analyst/Drafter of Proposal:
Beth Cook (093013)

Title of Proposal
An Act Concerning the Standard Valuation and Nonforfeiture Laws

Statutory Reference 38a-78 and 38a- 439

Proposal Summary

The amendments make changes to the Standard Valuation Law, 38a-78, to enable Principles Based Reserving (PBR) of life insurance companies' actuarial liabilities. This is an important and dynamic process to replace the current strictly formulaic approach at valuing life insurance reserves, which the Department and NAIC membership believes is overly static and in need of modernization. PBR uses risk analysis techniques such as modeling and simulation to better capture and evaluate various risks inherent in modern life insurance products. Elements of the modification include:

- The requirements for PBR. PBR will have the impact of allowing reserves to be established at truer level, reflecting company-specific and product-specific actuarial data.
- Requirements for life insurance companies to submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the Valuation Manual to facilitate regulatory review.
- Confidentiality provisions similar in principle to strict confidentiality provisions protecting sensitive financial and actuarial data provided to the Department to allow uninhibited access to this data so that reserves, and ultimately solvency, can be effectively monitored.
- Use of a Valuation Manual, which has recently been substantially completed by the NAIC. The Manual is intended to be dynamic to consider rapid changes in the marketplace, much as the NAIC Accounting and Procedures Manual, which sets out the details of Statutory Accounting, works now.
- Procedures for a vetting and approval process for future changes to the Valuation Manual, to include a supermajority approval of NAIC membership and approval of the Connecticut Insurance Commissioner.

The proposal also makes corresponding changes to the Standard NonForfeiture Law 38a-439 to recognize the use of the Standard Valuation Manual on policies issued following the operative date of the manual.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? There have been no direct changes in federal, state and local laws affecting the legislation. However, there was a change in the National Association of Insurance Commissioners' (NAIC) model in 2009 setting forth these changes and the NAIC Standard Valuation Manual, which is key to these revisions, is expected to be completed this autumn.

(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? This bill is a modernization of the existing Standard Valuation Law which has been adopted in every state (including CT) plus DC and Puerto Rico. Every state legislature is meeting in 2013 (including several that will not meeing in 2014), but it is too early to quantify how many will take up the SVL revisions.

(3) Have certain constituencies called for this action? By revising the model in a vote of all member jurisdictions, the NAIC has called for this action, and the life and annuity industry (through the American Council of Life Insurers) expressed unqualified support on an August 18, 2012, conference call of the NAIC Life Insurance and Annuities Committee.

(4) What would happen if this was not enacted in law this session? If this is not enacted this session, we will introduce it again next session. As noted above, this bill has the support of both regulators and the industry. It is the product of a multi-year process that has considered industry concerns that modernization of the current law is needed to address the evolution of products to meet consumer interests, along with regulatory concerns for maintaining policyholder protections.

- **Origin of Proposal** **_X__ New Proposal** **___ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package? LCO, The Department and Industry had difficulty coming up with a consensus document
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal? Yes
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation? IAC, ACLI, NAIC, CID

(4) *What was the last action taken during the past legislative session? J.F.ed from the Insurance Committee*

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency): NONE

Agency Name:

Agency Contact (name, title, phone):

Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
N/A

State N/A

Federal
N/A

Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

The revisions to the Standard Valuation Law will authorize implementation of Principal Based Reserving (PBR), which is a more dynamic system of valuation than what is currently used, for policies issued after its effective date. The system that is being replaced is a formulaic approach, which is somewhat rigid and which can result in reserves being overstated or understated for particular companies and products. The Department, and the consensus of NAIC membership, is that the PBR approach will provide a more accurate or "right sized" valuation of a life insurer's policyholder liabilities.

AN ACT CONCERNING STANDARD VALUATION and STANDARD NONFORFEITURE LAWS

Be it enacted by the Senate and House of Representatives in General Assembly convened
Section 38a-78 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) For the purposes of this section the following definitions shall apply on or after the operative date of the valuation manual:

(1) The term "accident and health insurance" means a policy or contract that incorporates morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

(2) The term "appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in subsection (f) of this section.

(3) The term "company" means an entity, which has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts (i) in this State and has at least one such policy in force or on claim or (ii) in any state and holds, or is required to hold, a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in this State.

(4) The term "deposit-type contract" means contracts that do not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

(5) The term "life insurance" means policies or contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

(6) The term "NAIC" means the National Association of Insurance Commissioners.

(7) The term "policyholder behavior" means any action a policyholder, contract holder or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this section including, but not limited to, lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

(8) The term "principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is required to comply with subsection (s) of this section as specified in the valuation manual.

(9) The term "qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements and who meets the requirements specified in the valuation manual.

(10) The term "tail risk" means a risk that occurs either where the frequency of low probability events is higher than expected under a normal probability distribution or where there are observed events of very significant size or magnitude.

(11) The term "valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in this section or as subsequently amended.

[(a)] (b) (1) The commissioner shall annually value, or cause to be valued, the reserve liabilities[,] (hereinafter called reserves)[,] for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurance company doing business in this state issued prior to the operative date of the valuation manual ,except that in the case of an alien company, the valuation shall be limited to its United States business, [and may certify the amount of any such reserves, specifying the mortality table or tables, rate or rates of interest, and methods, including net level premium method or other, used in the calculation of such reserves]. In calculating such reserves, [he] the commissioner may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves [herein] required of any foreign or alien company, [he] the commissioner may accept [any] a valuation made, or caused to be made, by the insurance [supervisory] regulatory official of any state or other jurisdiction when such valuation complies with the minimum standard [herein] provided in this section. [and if the official of such state or jurisdiction accepts as sufficient and valid for all legal purposes the certificate of valuation of the commissioner when such certificate states the valuation to have been made in a specified manner according to which the aggregate reserves would be at least as large as if they had been computed in the manner prescribed by the law of that state or jurisdiction.]

(2)The provisions set forth in subsections (i), (j), (k), (l), (m), (n), (o), (p), and (q) of this section shall apply to all policies and contracts, as appropriate, subject to this section issued on or after the date of a company's election to comply with this section as revised to 1981 or January 1, 1981, whichever occurred first, and prior to the operative date of the valuation manual; and the provisions set forth in subsections (r) and (s) shall not apply to any such policies and contracts.

(3) The minimum standard for the valuation of policies and contracts issued prior to the effective date specified in accordance with the provisions of subsection (h) of section 38-130e of the general statutes, revision of 1958, revised to 1981, shall be that provided by section 38a-77 of the general statutes.

(4) For policies and contracts issued on or after the operative date of the valuation manual, the commissioner shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance contracts, annuity and pure endowment contracts, accident and health contracts, and deposit-type contracts of every company. In lieu of the valuation of the reserves required of a foreign or alien company, the commissioner may accept a valuation made, or caused to be

made, by the insurance regulatory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this section.

(5) The provisions set forth in subsections (q), (r) and (s) of this act shall apply to all policies and contracts issued on or after the operative date of the valuation manual.

[(b)(1) Every life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulation are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this state. The commissioner by regulation shall define the specifics of this opinion and add any other items deemed to be necessary to its scope.

(2) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 1991.

(3) The opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by regulation.

(4) The opinion shall be based on standards adopted from time to time by the actuarial standards board and on such additional standards as the commissioner may by regulation prescribe.

(5) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance [supervisory]regulatory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(6) For the purposes of this section, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements set forth in regulations the commissioner may prescribe.

(7) Except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision or conduct with respect to the actuary's opinion.

(8) Disciplinary action by the commissioner against the company or the qualified actuary shall be as defined in such regulations by the commissioner.

(9) A memorandum, in form and substance acceptable to the commissioner as specified by regulation, shall be prepared to support each actuarial opinion.

(10) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified by regulation or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the regulations or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified

actuary at the expense of the company to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the commissioner.

(11) Any memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection therewith, shall be kept confidential by the commissioner and shall not be made public and shall not be subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required by this section or by regulations adopted under this section provided the memorandum or other material may otherwise be released by the commissioner (A) with the written consent of the company or (B) upon the request of the American Academy of Actuaries stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material. Once any portion of the confidential memorandum is referred to by the company in its marketing or is referred to before any governmental agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum shall no longer be confidential.

(12) Any regulation adopted by the commissioner under the provisions of this subsection shall be adopted in accordance with the provisions of chapter 54.

(c)(1) Every life insurance company, except as exempted by or pursuant to regulation, shall annually include in the opinion required by subdivision (1) of subsection (b) of this section, an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulation, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(2) The commissioner may provide by regulation for a transition period for establishing any higher reserves which the qualified actuary may deem necessary in order to render the opinion required by this section.]

(c) For actuarial opinions prior to the operative date of the valuation manual,

(1) Every life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulations adopted in accordance with the provisions of Chapter 54 are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this state. The commissioner shall define by regulation the specifics of this opinion and add any other items deemed to be necessary to its scope.

(2) Unless exempted by regulations, adopted in accordance with the provisions of Chapter 54, every life insurance company shall also annually include in the opinion required by subdivision (1) of this

subsection, an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulation, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(3) The commissioner may provide by regulations adopted in accordance with the provisions of Chapter 54 for a transition period for establishing any higher reserves that the qualified actuary may deem necessary in order to render the opinion required by this section.

(d) Each opinion required by subsection (c)(2) shall be governed by the following provisions:

(1) A memorandum, in form and substance acceptable to the commissioner as specified by regulations adopted in accordance with the provisions of Chapter 54, shall be prepared to support each actuarial opinion.

(2) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified by regulations adopted in accordance with the provisions of Chapter 54 or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the regulations or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner.

(e) Every opinion required by subsection (c) shall be governed by the following provisions:

(1) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 1991.

(2) The opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by regulation.

(3) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such additional standards as the commissioner may by regulation prescribe.

(4) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance regulatory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(5) For the purposes of this subsection, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements set forth in the regulation.

(6) Except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person (other than the insurance company and the commissioner) for any act, error, omission, decision or conduct with respect to the actuary's opinion.

(7) Except as provided in subdivisions (11), (12) and (13); documents, materials or other information in the possession or control of the Department of Insurance that are a memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection with the memorandum, shall be confidential by law and privileged, shall not be subject to sections 1-200 et seq. of the General Statutes, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

(8) Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any civil action concerning any confidential documents, materials or information subject to subdivision (7).

(9) In order to assist in the performance of the commissioner's duties, the commissioner:
(A) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subdivision (7) with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(B) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(C) May enter into agreements governing sharing and use of information consistent with subdivisions (7), (8) and (9).

(10) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subdivision (9).

(11) A memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection with the memorandum, may be subject to subpoena for the purpose of defending an action seeking damages from the actuary submitting the memorandum by reason of an action required by this subsection or by regulations promulgated hereunder.

(12) The memorandum or other material may otherwise be released by the commissioner (A) with the written consent of the company or (B) upon the request of the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material.

(13) Once any portion of the confidential memorandum is referred to by the company in its marketing or is referred to by a governmental agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum shall be no longer confidential.

(f) For actuarial opinions of reserves after the operative date of the valuation manual,

(1) Every company with outstanding life insurance contracts, accident and health insurance contracts or deposit-type contracts in this State and subject to regulation by the commissioner shall annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this State. The valuation manual will prescribe the specifics of this opinion including any items deemed to be necessary to its scope.

(2) Every company with outstanding life insurance contracts, accident and health insurance contracts or deposit-type contracts in this State and subject to regulation by the commissioner, except as exempted in the valuation manual, shall also annually include in the opinion required by subdivision (1) of this subsection, an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(g) Each opinion required by subsection (f) shall be governed by the following provisions:

(1) A memorandum, in form and substance as specified in the valuation manual, and acceptable to the commissioner, shall be prepared to support each actuarial opinion.

(2) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified in the valuation manual or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner.

(h) Every opinion subject to subsections (f) and (g) shall be governed by the following provisions:

(1) The opinion shall be in form and substance as specified in the valuation manual and acceptable to the commissioner.

(2) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after the operative date of the valuation manual.

(3) The opinion shall apply to all policies and contracts subject to subsection (f)(2), plus other actuarial liabilities as may be specified in the valuation manual.

(4) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board or its successor, and on such additional standards as may be prescribed in the valuation manual.

(5) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance regulatory official of another State if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this State.

(6) Except in cases of fraud or willful misconduct, the appointed actuary shall not be liable for damages to any person (other than the insurance company and the commissioner) for any act, error, omission, decision or conduct with respect to the appointed actuary's opinion.

[(d)] (i) Except as otherwise provided in subsections [(e), (f) and (l)] (j), (k) and (q) of this section, the minimum standard for the valuation of all such policies and contracts issued prior to the effective date of a company's election to comply with this section specified in accordance with the provisions of subsection (h) of section 38-130e of the general statutes, revision of 1958, revised to 1981 as revised to 1981, or January 1, 1981, whichever occurred first, shall be that provided by section 38a-77 of the general statutes[the laws in effect immediately prior to such date], except that the minimum standard for the valuation of annuities and pure endowments purchased prior to January 1, 1973, under group annuity and pure endowment contracts shall be the 1971 Group Annuity Mortality Table, or any modification of this table approved by the commissioner, and an interest rate of five per cent per annum. Except as otherwise provided in subsections [(e), (f) and (l)] (j), (k) and (q) of this section, the minimum standard for the valuation of all such policies and contracts issued on and after such effective date shall be the commissioners' reserve valuation methods defined in subsections [(g), (h) and (j)] (l), (m), (o) and (q) of this section with four and one-half per cent (4 ½%) interest [for all other such policies and contracts] and the following tables: (1) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies, the Commissioners' 1958 Standard Ordinary Mortality Table for such policies issued prior to the compliance date established by subdivision (11) of subsection (e) of section 38a-439, provided that for any category of such policies issued on female risks, all modified net premiums and present values referred to in this section may be calculated according to an age not more than six years younger than the actual age of the insured and for such policies issued on or after the compliance date established by subdivision (11) of subsection (e) of section 38a-439, (A) the Commissioners' 1980 Standard Ordinary Mortality Table, or (B) at the election of the company for any one or more specified plans of life insurance, the Commissioners' 1980 Standard Ordinary Mortality Table with ten-year select mortality factors, or (C) on or after January 1, 2005, until January 1, 2009, at the election of the company for any one or more specified plans of life insurance issued on or after January 1, 2004, on the basis of the Commissioners' 2001 Standard Ordinary Mortality Table, except that with respect to such plans issued before April 1, 2005, such mortality table shall be used solely for the basis of valuation and nonforfeiture and shall not be used to increase the previously agreed required premium, or (D) issued on or after January 1, 2009, the Commissioners' 2001 Standard Ordinary Mortality Table, or (E) any ordinary mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54 for use in determining the minimum standard of valuation for such policies; (2) for all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies, the Commissioners' 1961 Standard Industrial Mortality

Table or any industrial mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54 for use in determining the minimum standard of valuation for such policies; (3) for total and permanent disability benefits in or supplementary to ordinary policies or contracts, the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54 for use in determining the minimum standard of valuation for such policies. These tables shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies; (4) for accidental death benefits in or supplementary to policies, the 1959 Accidental Death Benefits Table or any accidental death benefits table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54 for use in determining the minimum standard of valuation for such policies. These tables shall be combined with a mortality table permitted for calculating the reserves for life insurance policies; and (5) for group life insurance, life insurance issued on the substandard basis and other special benefits, such tables as may be approved by the commissioner.

[(e)] (j) Except as otherwise provided in subsection [(f)] (k) of this section, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the effective date as specified in accordance with the provisions of subsection (h) of section 38-130e of the general statutes, revision of 1958, revised to 1981, or January 1, 1981, whichever occurred first , and for all annuities and pure endowments purchased on or after such effective date under group annuity and pure endowment contracts, shall be the [commissioners] commissioners' reserve valuation methods defined in subsections [(g) and (h)] (l) and (m) of this section and the following tables and interest rates: (1) For individual single premium immediate annuity contracts issued on or after such effective date, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table or any individual annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54 for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the commissioner, and seven and one-half per cent interest; (2) for individual annuity and pure endowment contracts issued on or after such effective date, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table or any individual annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54 for use in determining the minimum standard of valuation for such contract, or any modification of these tables approved by the commissioner, and five and one-half per cent interest for single premium deferred annuity and pure endowment contracts and four and one-half per cent interest for all other such annuity and pure endowment contracts; (3) for all annuities and pure endowments purchased on or after such effective date under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table or any group annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54

for use in determining the minimum standard of valuation for such annuities and pure endowments, or any modification of these tables approved by the commissioner, and seven and one-half per cent interest.

[(f)] (k) (1) The interest rates used in determining the minimum standard for the valuation of the following shall be the calendar year statutory valuation interest rates as defined in this subsection: (A) Life insurance policies issued in a particular calendar year, on or after the compliance date established by subdivision (11) of subsection (e) of section 38a-439, (B) Individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1982, (C) [Annuities] annuities and pure endowments purchased in a particular calendar year on or after January 1, 1982, under group annuity and pure endowment contracts, and (D) the net increase, if any, in a particular calendar year after January 1, 1982, in amounts held under guaranteed interest contracts [shall be the calendar year statutory valuation interest rates as defined in this subsection].

(2) The calendar year statutory valuation interest rates, I, shall be determined as follows and the results rounded to the nearest one-quarter of one per cent:

(A) For life insurance,

$$I = .03 + W\,(R_1 - .03) + \frac{W}{2}\,(R_2 - .09);$$

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options,

$$I = .03 + W(R - .03),$$

Where R_1 is the lesser of R and .09,
R_2 is the greater of R and .09,
R is the reference interest rate defined in subdivision (4) of this subsection and
W is the weighting factor defined in subdivision (3) of this subsection.

(C) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in subparagraph (B), the formula for life insurance stated in subparagraph (A) shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten years and the formula for single premium immediate annuities stated in subparagraph (B) shall apply to annuities and guaranteed interest contracts with guarantee durations of ten years or less.

(D) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in subparagraph (B)

shall apply.

(E) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in subparagraph (B) shall apply.

(F) If the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this subdivision differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one- half of one per cent, the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the foregoing, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980 using the reference interest rate defined for 1979 and shall be determined for each subsequent calendar year regardless of the compliance date established by subdivision (11) of subsection (e) of section 38a-439;

(3) The weighting factors referred to in the formulas stated in subdivision (2) of this subsection are given in the following tables:

(A) Weighting Factors For Life Insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy.

(B) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options: .80

(C) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in subparagraph (B), shall be as specified in tables (i), (ii) and (iii) according to the rules and definitions in (iv), (v) and (vi):

(i) For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration (Years)	Weighting Factor For Plan Type		
	A	B	C
5 or less	.80	.60	.50
More than 5, not more than 10	.75	.60	.50
More than 10, not more than 20	.65	.50	.45
More than 20	.45	.35	.35

(ii) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in (i) increased by:

	Weighting Factor For Plan Type		
More than 10 not more than 20:	A	B	C
More than 10 not more than 20:	.15	.25	.05

(iii) For annuities and guaranteed interest contracts valued on an issue year basis (other than those with no cash settlement options) that do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than twelve months beyond the valuation date, the factors shown in (i) or derived in (ii) increased by:

	Weighting Factor For Plan Type		
More than 10 not more than 20:	A	B	C
More than 10 not more than 20:	.05	.05	.05

(iv) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of twenty years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(v) Plan type as used in the tables in subparagraph (C) is defined as follows:

a. Plan Type A: At any time policyholder may withdraw funds only: (1) With an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) without such adjustment but in installments over five years or more, or (3) as an immediate life annuity, or (4) no withdrawal permitted.

b. Plan Type B: Before expiration of the interest rate guarantee, policyholder may withdraw funds only: (1) With an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) without such adjustment but in installments over five years or more, or (3) no withdrawal permitted. At the end of the interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five years.

c. Plan Type C: Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five years either: (1) Without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(vi) A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. As used in this subsection, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract. The change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in fund;

(4) The reference interest rate referred to in subdivision (2) of this subsection shall be defined as follows: [a.] (A) For life insurance, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June thirtieth of the calendar year preceding the year of issue, of the monthly average of the composite yield on seasoned corporate funds, [Moody's Corporate Bond Yield Average-Monthly Average Corporates,] as published by Moody's Investors Service, Inc.; [b.] (B) for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve months, ending on June thirtieth of the calendar year of issue

or year of purchase of the monthly average of the composite yield on seasoned corporate bonds, [Moody's Corporate Bond Yield Average-Monthly Average Corporates,] as published by Moody's Investors Service, Inc.;[c.] (C) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in b. above, with guarantee duration in excess of ten years, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or purchase of the monthly average of the composite yield on seasoned corporate bonds, [Moody's Corporate Bond Yield Average-Monthly Average Corporates,] as published by Moody's Investors Service, Inc.;[d.] (D) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in b. above, with guarantee duration of ten years or less, the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds,[Moody's Corporate Bond Yield Average-MonthlyAverage Corporates,] as published by Moody's Investors Service, Inc.; [e.] (E) for other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, [Moody's Corporate Bond Yield Average-Monthly Average Corporates,] as published by Moody's Investors Service, Inc.; [f.] (F) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in b. above, the average over a period of twelve months, ending on June thirtieth of the calendar year of the change in the fund, of the monthly average of the composite yield on seasoned corporate bonds, [Moody's Corporate Bond Yield Average-Monthly Average Corporates,] as published by Moody's Investors Service, Inc.

(5) In the event that the monthly average of the composite yield on seasoned corporate bonds, [Moody's Corporate Bond Yield Average-Monthly Average Corporates] is no longer published by Moody's Investors Service, Inc., or in the event that the National Association of Insurance Commissioners determines that the monthly average of the composite yield on seasoned corporate bonds, [Moody's Corporate Bond Yield Average-Monthly Average Corporates] as published by Moody's Investors Service, Inc. is no longer appropriate for the determination of the reference interest rate, an alternative method for determination of the reference interest rate, which is adopted by the National Association of Insurance Commissioners and approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54, may be substituted.

[(g)] (l) Except as otherwise provided in subsections [(h), (j) and (l)] (m), (o) and (q) of this section, reserves according to the [commissioner's] commissioners' reserve valuation method, for the life insurance and endowment benefits of policies 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 policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the policy and the excess of (1) over (2), as follows: (1) A net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy

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 policy 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 policy, and (2) a net one year term premium for such benefits provided for in the first policy year provided that for any life insurance policy issued on or after January 1, 1985, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioners reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in subsection [(j)] (o) of this section, be the greater of the reserve as of such policy anniversary calculated as described in this subsection and the reserve as of such policy anniversary calculated as described in this subsection but with the value defined in subdivision (1) of this subsection being reduced by fifteen per cent of the amount of such excess first year premium, all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date, the policy being assumed to mature on such date as an endowment, and the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison, the mortality and interest bases stated in subsections [(e)] (i) and [(f)] (k) of this section shall be used. Reserves according to the [commissioners] commissioners' reserve valuation method for: (A) Life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums; (B) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended; (C) disability and accidental death benefits in all policies and contracts; and (D) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of this subsection.

[h] (m) This subsection shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended. Reserves according to the [commissioners] commissioners' annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate, or rates, specified in such

contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

[(i)] (n) (1) In no event shall a company's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued on or after the [effective] date [as specified in accordance with the provisions of subsection (h) of section 38-130e of the general statutes, revision of 1958, revised to 1981] of a company's election to comply with this section as amended to 1981, or January 1, 1981, whichever occurred first, be less than the aggregate reserves calculated in accordance with the methods set forth in subsections [(f), (g), (i) and (k)] (l), (m), (o) and (p) of this section, and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies; (2) in no event shall the aggregate reserves for all policies, contracts and benefits be less than the aggregate reserves determined by the [qualified] appointed actuary to be necessary to render the opinion required by subsection [(b)] (d) of this section; (3) reserves for any category of policies, contracts or benefits as established by the commissioner may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for such category than those calculated according to the minimum standard herein provided, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be greater than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided [in the policies or contracts; (4) any such company which at any time shall have adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard herein provided may, with the approval of the commissioner, adopt any lower standard of valuation, but not lower than the minimum herein provided; provided, for the purposes of this subsection, the holding of additional reserves previously determined by [a qualified] the appointed actuary to be necessary to render the opinion required by [subsection (b)] subsections (c) and (f) of this section shall not be deemed to be the adoption of a higher standard of valuation.

[(j)] (o) If in any contract year the gross premium charged by [any life insurance] a company on any policy or contract, in force as of or written after the effective date as specified in accordance with the provisions of subsection (h) of section 38-130e of the general statutes, revision of 1958, revised to 1981, or January 1, 1981, whichever occurred first, is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the most recent minimum valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for such policy or contract, or the reserve calculated by the method actually used for such policy or contract but using the minimum standards of mortality and rate of interest in effect in the year that the policy or contract was issued and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this subsection are those standards stated in subsections [(d) and (f)] (i) and (k) of this section. For any life insurance policy issued on or after January 1, 1985, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of this subsection shall be applied as if the method actually used in calculating the reserve for such policy were the method

described in subsection [(g)] (l) of this section. The minimum reserve at each policy anniversary of such policy shall be the greater of the minimum reserve calculated in accordance with subsection [(g)] (l), of this section and the minimum reserve calculated in accordance with this subsection.

[(k)] (p) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such nature that the minimum reserves cannot be determined by the methods described in subsections [(g), (h), and (j)] (l), (m) and (o) of this section, the reserves which are held under any such plan must be appropriate in relation to the benefits and the pattern of premiums for that plan, and be computed by a method which is consistent with the principles of this standard valuation law, as determined by regulations adopted by the commissioner in accordance with the provisions of chapter 54.

[(l) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 containing the minimum standards applicable to the valuation of health insurance plans.]

(q) For accident and health insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under subsection (b)(4) and (5). For accident and health insurance contracts policies or contracts, in force as of or written after the effective as specified in accordance with the provisions of subsection (h) of section 38-130e of the general statutes, revision of 1958, revised to 1981, or January 1, 1981, whichever occurred first and prior to the operative date of the valuation manual the minimum standard of valuation is the standard adopted by the commissioner by regulation.

(r) (1)For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under subsection (b)(4) and (5), except as provided under subdivisions (5) and (7) of this subsection.

(2)(A) The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(i) The valuation manual has been adopted by the NAIC by an affirmative vote of at least forty-two (42) members, or three-fourths of the members voting, whichever is greater.

(ii) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by States representing greater than 75% of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident and health annual statements; health annual statements; or fraternal annual statements.

(iii) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two (42) of the following fifty-five (55) jurisdictions: The fifty States of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico.

(B) After all events set forth in subparagraph (A) of this subdivision have occurred, the commissioner shall certify that all such events have occurred and notify companies of such certification and the effective date of the operation of the valuation manual.

(3)(A) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on January 1 following the date when the change to the valuation manual has been adopted by the NAIC by an affirmative vote representing:

(i) At least three-fourths (3/4) of the members of the NAIC voting, but not less than a majority of the total membership, and

(ii) Members of the NAIC representing jurisdictions totaling greater than 75% of the direct premiums written as reported in the following annual statements most recently available prior to the vote in subdivision (3)(A) of this subsection: life, accident and health annual statements, health annual statements, or fraternal annual statements.

(B) After both events set forth in subparagraph (A) of this subdivision have occurred, the commissioner shall certify that both such events have occurred and notify companies of such certification, the change to the valuation manual and the effective date of such change.

(4) The valuation manual must specify all of the following:

(A) Minimum valuation standards for and definitions of the policies or contracts subject to subsections (b) (4) and (5). Such minimum valuation standards shall be:

(i) The commissioners' reserve valuation method for life insurance contracts, other than annuity contracts, subject to subsection (b)(4) and (5);

(ii) The commissioners' annuity reserve valuation method for annuity contracts subject to subsection (b) (4) and (5); and

(iii) Minimum reserves for all other policies or contracts subject to subsection (b)(4) and (5).

(B) Which policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation in subsection (s)(1) and the minimum valuation standards consistent with those requirements;

(C) For policies and contracts subject to a principle-based valuation under subsection (s):

(i) Requirements for the format of reports to the commissioner under subsection (s) (2) (C) and which shall include information necessary to determine if the valuation is appropriate and in compliance with this section;

(ii) Assumptions shall be prescribed for risks over which the company does not have significant control or influence.

(iii) Procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of such procedures.

(D) For policies not subject to a principle-based valuation under subsection (s) the minimum valuation standard shall either

(i) Be consistent with the minimum standard of valuation prior to the operative date of the valuation manual; or

(ii) Develop reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring.

(E) Other requirements, including, but not limited to, those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules and internal controls; and

(F) The data and form of the data required under subsection (t), with whom the data must be submitted, and may specify other requirements including data analyses and reporting of analyses.

(5) In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the commissioner, in compliance with this section, then the company shall, with respect to such requirements, comply with minimum valuation standards prescribed by the commissioner by regulation.

(6) The commissioner may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in this section. The commissioner may rely upon the opinion, regarding provisions contained within this section, of a qualified actuary engaged by the commissioner of another State, district or territory of the United States. As used in this paragraph, term "engage" includes employment and contracting.

(7) The commissioner may require a company to change any assumption or method that in the opinion of the commissioner is necessary in order to comply with the requirements of the valuation manual or this section; and the company shall adjust the reserves as required by the commissioner.

(s)(1)A company must establish reserves using a principle-based valuation that meets the following conditions for policies or contracts as specified in the valuation manual:

(A) Quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. For polices or contracts with significant tail risk, reflects conditions appropriately adverse to quantify the tail risk.

(B) Incorporate assumptions, risk analysis methods and financial models and management techniques that are consistent with, but not necessarily identical to, those utilized within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods.

(C) Incorporate assumptions that are derived in one of the following manners:

(i) The assumption is prescribed in the valuation manual.

(ii) For assumptions that are not prescribed, the assumptions shall:

(a) Be established utilizing the company's available experience, to the extent it is relevant and statistically credible; or

(b) To the extent that company data is not available, relevant, or statistically credible, be established utilizing other relevant, statistically credible experience.

(D) Provide margins for uncertainty including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

(2) A company using a principle-based valuation for one or more policies or contracts subject to this section as specified in the valuation manual shall:

(A) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual.

(B) Provide to the commissioner and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. Such controls shall be designed to assure that all material risks inherent in the liabilities and associated assets subject to such valuation are included in the valuation, and that valuations are made in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year.

(C) Develop, and file with the commissioner upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

(3) A principle-based valuation may include a prescribed formulaic reserve component.

(t) A company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual.

(u)(1) For purposes of this subsection, "Confidential Information" shall mean:

(A) A memorandum in support of an opinion submitted under subsection (f) of this section and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such memorandum;

(B) All documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in the course of an examination made under subsection (r)(6) of this section; provided, however, that if an examination report or other material prepared in connection with an examination made under sections 38a-14 and 38a-14a is not held as private and confidential information under the sections 38a-14 and 38a-14a, an examination report or other material prepared in connection with an examination made under subsection (r)(6) of this section shall not be "Confidential Information" to the same extent as if such examination report or other material had been prepared under sections 38a-14- and 38a-14a;

(C) Any reports, documents, materials and other information developed by a company in support of, or in connection with, an annual certification by the company under subsection (s)(2)(B) of this section evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such reports, documents, materials and other information;

(D) Any principle-based valuation report developed under subsection (s)(2)(C) of this section and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such report; and

(E) Any documents, materials, data and other information submitted by a company under subsection (t) of this section (collectively, "experience data") and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created or produced in connection with such experience data, in each case that include any potentially company-identifying or personally identifiable information, that is provided to or obtained by the commissioner (together with any "experience data", the "experience materials") and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such experience materials.

(2) Privilege for, and Confidentiality of, Confidential Information

(A) Except as provided in this subsection, a company's Confidential Information is confidential by law and privileged, and shall not be subject to disclosure under section 1-210 of the General Statutes, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action; provided, however, that the commissioner is authorized to use the Confidential Information in the furtherance of any regulatory or legal action brought against the company as a part of the commissioner's official duties.

(B) Neither the commissioner nor any person who received Confidential Information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any Confidential Information.

(C) In order to assist in the performance of the commissioner's duties, the commissioner may share Confidential Information (i) with other state, federal and international regulatory agencies and with the NAIC and its affiliates and subsidiaries and (ii) in the case of Confidential Information specified in subsections (u)(1)(A) and (u)(1)(D) only, with the Actuarial Board for Counseling and Discipline or its successor upon request stating that the Confidential Information is required for the purpose of professional disciplinary proceedings and with state, federal and international law enforcement officials; in the case of (i) and (ii), provided that such recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of such documents, materials, data and other information in the same manner and to the same extent as required for the commissioner.

(D) The commissioner may receive documents, materials, data and other information, including otherwise confidential and privileged documents, materials, data or information, from the NAIC and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions and from the Actuarial Board for Counseling and Discipline or its successor and shall maintain as confidential or privileged any document, material, data or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or other information.

(E) The commissioner may enter into agreements governing sharing and use of information consistent with this subsection.

(F) No waiver of any applicable privilege or claim of confidentiality in the Confidential Information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsection (u)(2)(C)).

(G) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under subdivision (2) of this section shall be available and enforced in any proceeding in, and in any court of, this State.

(H) In this subsection, "regulatory agency," "law enforcement agency" and the "NAIC" include, but are not limited to, their employees, agents, consultants and contractors.

(3) Notwithstanding subdivision (2) any Confidential Information specified in subdivisions(1) (A) and (1) (D)):

(A) May be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under subsection (c) of this section or principle-based valuation report developed under subsection (s) (2) (C) of this section by reason of an action required by this section or by regulations promulgated hereunder;

(B) May otherwise be released by the commissioner with the written consent of the company; and

(C) Once any portion of a memorandum in support of an opinion submitted under subsection (c) of this section or a principle-based valuation report developed under subsection (s) (2) (C) of this section is cited by the company in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of such memorandum or report shall no longer be confidential.

[(m)] (v) The provisions of sections 38a-77 and 38a-433 shall apply to policies issued by a company before the date of its election to comply with this section as revised to 1981 or January 1, 1981, whichever occurred first. The provisions of section 38-130e of the general statutes, revision of 1958, revised to 1981, shall apply to policies issued by a company on and after the date of such election or on and after January 1, 1981, whichever occurred first, and before October 1, 1981.

Sec. 2. Section 38a-439 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(a) In the case of policies issued on and after the effective date specified in accordance with the provisions of subsection (g) of section 38-130c of the general statutes, revision of 1958, revised to 1981, no policy of life insurance, except as stated in subsection (i) of this section, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements hereinafter specified and are substantially in compliance with subsection (h) of this section: (1) A statement that, in the event of default in any premium payment, the company will grant, upon request by the policyholder made in accordance with the policy not later than sixty days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of the due date, of such amount as may be hereinafter specified. In lieu of the stipulated paid-up nonforfeiture benefit, the company may substitute, upon request by the policyholder made in accordance with the policy not later than sixty days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits; (2) a statement that, upon surrender of the policy within sixty days after the due date of any premium payment in default after premiums have been paid for at least three full years in the case of ordinary insurance or five full years in the case of industrial insurance, the company will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as may be hereinafter specified; (3) a statement that a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than sixty days after the due date of the premium in default; (4) a statement that, if the policy shall have become paid-up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, the company will pay, upon surrender of the policy within thirty days after any policy anniversary, a cash surrender value of such amount as may be hereinafter specified; (5) in the case of policies which, on a basis guaranteed in the policy, provide for unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy; in the case of all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the mortality table and interest rate used in calculating the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first twenty policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the company on the policy; (6) a statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the state in which the policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the company on the policy; if a detailed

statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation has been filed with the supervisory official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy. Any of the foregoing provisions or portions thereof not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy. The company shall reserve the right to defer the payment of any cash surrender value for a period of six months after demand therefor with surrender of the policy.

(b) Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by subsection (a) of this section, shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of: (1) The then present value of the adjusted premiums as defined in subsections (d) and (e) of this section, corresponding to premiums which would have become due on and after such anniversary, and (2) the amount of any indebtedness to the company on the policy; provided that for any policy issued on or after the compliance date established by subdivision (11) of subsection (e) of this section, which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value shall be an amount not less than the sum of such value for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and for a policy which provides only the benefits otherwise provided by such rider or supplemental policy provision; provided, further, that for any family policy issued on or after the compliance date established by subdivision (11) of subsection (e) of this section, which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse attains the age of seventy-one, the cash surrender value shall be an amount not less than the sum of such value for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and for a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse. Any cash surrender value available within thirty days after any policy anniversary under any policy paid-up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by subsection (a) of this section, shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the company on the policy.

(c) Any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of such anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value which would have been required by this section in the absence of the condition that premiums shall have been paid for at least a specified period.

(d)(1) Except as provided in subdivision (3) of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding any extra premiums charged because of impairments or special hazards, that the present value, at the date of issue of the policy, of all such

adjusted premiums shall be equal to the sum of: (A) The then present value of the future guaranteed benefits provided for by the policy; (B) two per cent of the amount of insurance, if the insurance be uniform in amount, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with duration of the policy; (C) forty per cent of the adjusted premium for the first policy year; (D) twenty-five per cent of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less. In applying the percentages specified in subparagraphs (C) and (D) above, no adjusted premium shall be deemed to exceed four per cent of the amount of insurance or uniform amount equivalent thereto. The date of issue of a policy for the purpose of this subsection shall be the date on which the rated age of the insured is determined; (2) in the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount thereof for the purpose of this subsection shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy, provided in the case of a policy providing a varying amount of insurance issued on the life of a child under the age ten, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age ten was the amount provided by such policy at age ten; (3) the adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to: (A) The adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by (B) the adjusted premiums for such term insurance, the foregoing items (A) and (B) being calculated separately and as specified in subdivisions (1) and (2) of this subsection except that, for the purposes of subparagraphs (B), (C) and (D) of subdivision (1) of this subsection, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in subparagraph (B) of this subdivision shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in subparagraph (A) of this subdivision; (4) in the case of ordinary policies, all adjusted premiums and present values referred to in this section shall be calculated on the bases of the Commissioners' 1958 Standard Ordinary Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits provided such rate of interest shall not exceed five and one-half per cent per annum and provided, for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six years younger than the actual age of the insured; provided in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners' 1958 Extended Term Insurance Table; and provided further, for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner; (5) in the case of industrial policies, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the Commissioners' 1961 Standard Industrial Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits provided such rate of interest shall not exceed five and one-half per cent per annum; provided, in calculating the present value of any paid-up term insurance with accompanying pure

endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners' 1961 Industrial Extended Term Insurance Table; and provided further, for insurance issued on a substandard basis, the calculations of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner; and (6) the provisions of this subsection shall not apply to any policy issued on or after the compliance date applicable to the issuing company as determined by subdivision (11) of subsection (e) of this section.

(e) The provisions of this subsection shall apply to all policies issued on or after the compliance date established by subdivision (11) of this subsection. (1) Except as provided in subdivision (7) of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of: (A) The then present value of the future guaranteed benefits provided for by the policy; (B) one per cent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and (C) one hundred twenty-five per cent of the nonforfeiture net level premium as hereinafter defined, provided that in applying the percentage specified in this subparagraph, no nonforfeiture net level premium shall be deemed to exceed four per cent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined; (2) the nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits divided by the present value, at such date of issue, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium becomes due; (3) in the case of policies that, on a basis guaranteed in the policy, provide for unscheduled changes in benefits or premiums, or that provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change; (4) except as otherwise provided in subdivision (7) of this subsection, the recalculated future adjusted premiums for any such policy shall be the uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of (A) the sum of: (i) The then present value of the future guaranteed benefits provided for by the policy and (ii) the additional expense allowance, if any, over (B) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy; (5) the additional expense allowance, at the time of the change to the newly defined benefits or

premiums, shall be the sum of (A) one per cent of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and (B) one hundred twenty-five per cent of the increase, if positive, in the nonforfeiture net level premium; (6) the recalculated nonforfeiture net level premium shall be equal to the amount obtained by dividing (A) by (B) where (A) equals the sum of (i) the nonforfeiture net level premium applicable prior to the change, multiplied by the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium would have become due had the change not occurred, and (ii) the present value of the increase in future guaranteed benefits provided for by the policy, and (B) equals the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium becomes due; (7) notwithstanding any other provisions of this subsection, in the case of a policy issued on a substandard basis that provides reduced graded amounts of insurance so that, in each policy year, such policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis that provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis; (8) all adjusted premiums and present values referred to in this section shall be calculated: (A)(i) For all policies of ordinary insurance, on the basis of the Commissioners' 1980 Standard Ordinary Mortality Table or at the election of the company, for any one or more specified plans of life insurance, on the basis of the Commissioners' 1980 Standard Ordinary Mortality Table with ten-year select mortality factors, or (ii) on or after January 1, 2005, until January 1, 2009, at the election of the company for any one or more specified plans of life insurance issued on or after January 1, 2004, on the basis of the Commissioners' 2001 Standard Ordinary Mortality Table, except that with respect to such plans issued before April 1, 2005, such mortality table shall be used solely for the basis of valuation and nonforfeiture and shall not be used to increase the previously agreed required premium; or (iii) for all policies issued on or after January 1, 2009, and prior to the operative date of the Valuation Manual as specified in section 38a-78 subsection (r)(2), on the basis of the Commissioners' 2001 Standard Ordinary Mortality Table, or (iii) for policies issued after the operative date of the valuation manual as defined in section 38a-78 subsection (r) (2) the Commissioner's Standard mortality table as defined in the Valuation Manual for determining nonforfeiture values; (B) for all policies of industrial insurance, (i) issued prior to the operative date of the Valuation Manual as specified in section 38a-78 subsection (r)(2), on the basis of the Commissioners' 1961 Standard Industrial Mortality Table, or (ii) for policies issued after the operative date of the valuation manual as defined in section 38a-78 subsection (r) (2) the Commissioner's Standard mortality table as defined in the Valuation Manual for determining nonforfeiture values ; (C) for all policies issued in a particular calendar year, on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this subsection, for policies issued in that calendar year, provided, that: (i) At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this subsection, for policies issued in the immediately preceding calendar year; (ii) under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by subsection (a) of this section, shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any; (iii) a company may calculate the amount of any guaranteed paid-up

nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values; (iv) in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners' 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioners' 1961 Industrial Extended Term Insurance Table for policies of industrial insurance; (v) for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables; (vi) any ordinary mortality tables, adopted after 1980 by the National Association of Insurance Commissioners that are approved by regulations adopted by the commissioner, in accordance with the provisions of chapter 54, for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners' 1980 Standard Ordinary Mortality Table with or without ten-year select mortality factors or the Commissioners' 1980 Extended Term Insurance Table; (vii) any industrial mortality tables, adopted after 1980 by the National Association of Insurance Commissioners that are approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54, for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners' 1961 Standard Industrial Mortality Table or the Commissioners' 1961 Industrial Extended Term Insurance Table; (9) the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be (i) equal to one hundred twenty-five per cent of the calendar year statutory valuation interest rate for such policy as defined in the standard valuation law, rounded to the nearest one quarter of one per cent provided however that the nonforfeiture rate shall not be less than four percent, for policies issued prior to the operative date of the Valuation Manual as specified in section 38a-78 subsection (r)(2), or (ii) for policies issued after the operative date of the valuation manual as defined in section 38a-78 subsection (r) (2) the interest rates as defined in the Valuation Manual for determining nonforfeiture values ;
(10) notwithstanding any provision of the general statutes, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form that involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of such policy form; (11) on or after October 1, 1981, but prior to January 1, 1989, any company may file with the commissioner a written notice of its election to comply with the provisions of this subsection on or after a specified date and the provisions of this subsection shall apply to such company on or after such specified date, except that on or after January 1, 2005, but prior to January 1, 2009, any company may file with the commissioner a written notice of its election to comply with the provisions of this subsection on or after a specified date with respect to the Commissioners' 2001 Standard Ordinary Mortality Table and the provisions of this subsection shall apply to such company. The provisions of this subsection shall apply to policies issued by any company on or after January 1, 1989, except that the provisions of this subsection with respect to the Commissioners' 2001 Standard Ordinary Mortality Table shall apply to policies issued by any company on or after January 1, 2009.

(f) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance which is of such nature that minimum values cannot be determined by the methods described in subsections (a) to (e), inclusive, then: (1) The commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as are the minimum benefits otherwise required by subsections (a) to (e),

inclusive; (2) the commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds; (3) the cash surrender values and paid-up nonforfeiture benefits provided by such plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this section, as determined by regulations adopted by the commissioner in accordance with the provisions of chapter 54.

(g) Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in subsections (b), (c), (d), and (e) of this section may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall be not less than the amounts used to provide such additions. Notwithstanding the provisions of subsection (b) of this section, additional benefits payable: (1) In the event of death or dismemberment by accident or accidental means; (2) in the event of total and permanent disability; (3) as reversionary annuity or deferred reversionary annuity benefits; (4) as term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this section would not apply; (5) as term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is twenty-six, is uniform in amount after the child's age is one, and has not become paid-up by reason of the death of a parent of the child, and (6) as other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits, shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this section and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

(h) This subsection shall apply to all policies issued on or after January 1, 1985. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount which does not differ by more than two-tenths of one per cent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years, from the sum of the greater of zero and the basic cash value hereinafter specified and the present value of any existing paid-up additions less the amount of any indebtedness to the company under the policy. The basic cash value shall be equal to the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the company, if there had been no default, less the then present value of the nonforfeiture factors, as hereinafter defined, corresponding to premiums which would have become due on and after such anniversary; provided, that the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in subsection (b) or (d) of this section, whichever is applicable, shall be the same as are the effects specified in subsection (b) or (d) of this section, whichever is applicable, on the cash surrender values defined in the applicable subsection. The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in subsection (e) of this section. Except as is required by this subsection, such percentage shall be the same percentage for each policy year between the second policy anniversary and the later of (1) the fifth policy anniversary and (2) the first policy anniversary at which there is available under the policy, a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two-tenths of one per cent of either the amount of insurance, if the insurance be

uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and shall be such that no percentage after the later of the two policy anniversaries specified in this subsection may apply to fewer than five consecutive policy years; provided, that no basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in subsection (d) or (e) of this section, whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value. All adjusted premiums and present values referred to in this subsection shall, for a particular policy, be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the subsections of this section. The cash surrender values referred to in this subsection shall include any endowment benefits provided for by the policy. Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in a manner consistent with those specified for determining the analogous minimum amounts in subsections (a), (b), (c), (e) and (g) of this section. The amount of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those enumerated in subdivisions (1) to (6), inclusive, of subsection (g) of this section, shall conform with the principles of this subsection.

(i) This section shall not apply to any reinsurance, group insurance, pure endowment, annuity or reversionary annuity contract, or to any term policy of uniform amount which provides for no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of twenty years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy, or to any term policy of decreasing amount, which provides for no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in subsections (d) and (e) of this section, is less than the adjusted premium so calculated, on a term policy of uniform amount, or renewal thereof, which provides for no guaranteed nonforfeiture or endowment benefits issued at the same age and for the same initial amount of insurance and for a term of twenty years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy, or to any policy, which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in subsections (b), (c), (d) and (e) of this section, exceeds two and one-half per cent of the amount of insurance at the beginning of the same policy year or to any policy which shall be delivered outside this state through an agent or other representative of the company issuing the policy. For purposes of determining the applicability of this section, the age at expiration for a joint term life insurance policy shall be the age at expiration of the oldest life.

(j) The provisions of sections 38a-77 and 38a-433 shall apply to ordinary and industrial policies issued by a company before the date of its election to comply with section 38-130c of the general statutes, revision of 1958, revised to 1981, or January 1, 1981, whichever occurred first. The provisions of section 38-130c of the general statutes, revision of 1958, revised to 1981, shall apply to policies issued by a company on and after the date of such election or on and after January 1, 1981, whichever occurred first, and before October 1, 1981.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID1101ORSA.doc

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Insurance Department

Liaison: Jim Perras
Phone:860.297.3864
E-mail:Jim.Perras@ct.gov

Lead agency division requesting this proposal:
Financial Regulation

Agency Analyst/Drafter of Proposal:
Beth Cook

Title of Proposal

AAC RISK MANAGEMENT AND OWN RISK AND SOLVENCY ASSESSMENT MODEL ACT

Statutory Reference
New

Proposal Summary
To enact the NAIC RISK MANAGEMENT AND OWN RISK AND SOLVENCY ASSESSMENT MODEL ACT. The ORSA Model will be needed to be enacted in order for the Department to meet NAIC accreditation requirements. The ORSA Model is to provide requirements for maintaining a risk management framework and to provide guidance to insurers or insurance groups relating to filing ORSA summary reports to the Insurance Commissioner.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? NO

(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? In process

(3) Have certain constituencies called for this action? NAIC

(4) What would happen if this was not enacted in law this session? Need for accreditation review

- **Origin of Proposal** ___ **New Proposal** __x_ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
Industry issues

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
Yes, we've met with IAC and the language submitted is a consensus document

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
IAC, Travelers, ACLI, Megna

(4) What was the last action taken during the past legislative session? **Tabled for House Calendar**

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency) **N/A**

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) none
State none
Federal none
Additional notes on fiscal impact   none

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Sec. 1:
Identifies eff date of 1/1/15 and that this is applicable to all domestic insurers/insurance groups
Definitions
Requirement for insurer to maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing and reporting on its material and relevant risks
Requirement to conduct an ORSA Report annually
Requirements for the ORSA Summary Report
Exemption from ORSA criteria
Requirement to use ORSA Guidance Manual to prepare ORSA Summary Report
Confidentiality
Late filing penalties

AN ACT CONCERNING RISK MANAGEMENT AND OWN RISK AND SOLVENCY ASSESSMENTS FOR DOMESTIC INSURERS.

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

Section 1. (NEW) (*Effective January 1, 2015*) (a) As used in this section:

(1) "Insurance group" means those insurers and affiliates included within an insurance holding company system, as defined in section 38a-129 of the general statutes;

(2) "Insurer" has the same meaning as provided in section 38a-1 of the general statutes, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state;

(3) "NAIC" means the National Association of Insurance Commissioners;

(4) "ORSA" or "Own Risk and Solvency Assessment" means a confidential internal assessment conducted by an insurer or insurance group, appropriate to the nature, scale and complexity of such insurer or insurance group, of the material and relevant risks associated with the insurer or insurance group's current business plan and the sufficiency of capital resources to support those risks;

(5) "ORSA Guidance Manual" means the current version of NAIC's Own Risk and Solvency Assessment Guidance Manual, as amended from time to time;

(6) "ORSA Summary Report" means a confidential high-level summary of an insurer or insurance group's ORSA.

(b) (1) Each domestic insurer shall establish and maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing and reporting on its material and relevant risks. This requirement may be satisfied if the insurance group of which such insurer is a member maintains a risk management framework applicable to the operations of such insurer.

(2) Each domestic insurer or the insurance group of which such insurer is a member shall regularly conduct an ORSA consistent with a process comparable to that set forth in the ORSA Guidance Manual. Any change in the ORSA Guidance Manual shall be effective January first following the calendar year in which such change was adopted by NAIC. The ORSA shall be conducted at least annually and at any time when there are significant changes to the risk profile of such insurer or insurance group.

(c) Commencing January 1, 2015, upon request by the Insurance Commissioner, and not more than once each year, a domestic insurer shall submit to the commissioner an ORSA Summary Report and any combination of reports that together contain the information described in the ORSA Guidance Manual that is applicable to such insurer and insurance group. The date of submission of such report or reports shall be dependent upon when such insurer or insurance group conducts its internal strategic planning process. If the commissioner is the lead state commissioner, as determined by the procedures in NAIC's applicable financial analysis handbook, of the insurance group of which such insurer is a member, such insurer shall submit to the commissioner the reports required under this subsection once each year regardless of whether the commissioner has requested such reports. A domestic insurer may comply with this subsection by providing the most recent and substantially similar reports that were provided by such insurer or another member of the insurance group of which such insurer is a member to the insurance regulatory official of another state or a foreign jurisdiction and that provide information that is comparable to the information described in the ORSA Guidance Manual. Any such report in a language other than English shall be accompanied by a translation of that report into the English language.

(d) Each domestic insurer or the insurance group of which such insurer is a member shall prepare an ORSA Summary Report consistent with the standards set forth in the ORSA Guidance Manual. Such insurer or insurance group shall maintain documentation and supporting information of an ORSA and shall make such documentation and information available for examination upon request by the commissioner. The commissioner or the commissioner's designee shall review the ORSA Summary Report and such documentation or information using procedures similar to those currently used in the analysis and examination of multistate or global insurers and insurance groups.

(e) The ORSA Summary Report shall include the signature of the domestic insurer's or insurance group's chief risk officer or other executive having responsibility for the oversight of the insurer's enterprise risk management process, attesting that, to the best of such officer's or executive's belief and knowledge, the insurer applied the enterprise risk management process described in the ORSA Summary Report and that a copy of the report has been provided to the insurer's board of directors or appropriate committee thereof.

(f) The commissioner, after notice and hearing, may impose a civil penalty on a domestic insurer that fails, without just cause, to timely file an ORSA Summary Report, of one thousand dollars for each day the failure to file a report continues. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

(g) (1) A domestic insurer shall be exempt from the requirements of subsections (b) to (e), inclusive, of this section if (A) such insurer has annual direct written and unaffiliated assumed premiums, including international direct and assumed premiums but excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance

Program, of less than five hundred million dollars, and (B) the insurance group of which such insurer is a member has annual direct written and unaffiliated assumed premiums, including international direct and assumed premiums but excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program of less than one billion dollars.

(2) If an insurer qualifies for an exemption pursuant to subparagraph (A) of subdivision (1) of this subsection but the insurance group of which such insurer is a member does not qualify for an exemption pursuant to subparagraph (B) of subdivision (1) of this subsection, the ORSA Summary Report shall include every insurer within such insurance group. This requirement may be satisfied by the submission of more than one ORSA Summary Report for any combination of insurers, provided such combination of reports includes every insurer within such insurance group.

(3) If an insurer does not qualify for an exemption pursuant to subparagraph (A) of subdivision (1) of this subsection but the insurance group of which such insurer is a member qualifies for an exemption pursuant to subparagraph (B) of subdivision (1) of this subsection, the only ORSA Summary Report required shall be the report applicable to such insurer.

(4) An insurer that does not qualify for an exemption pursuant to subparagraph (A) of subdivision (1) of this subsection may apply to the commissioner for a waiver from the requirements of subsections (b) to (e), inclusive, of this section, based on unique circumstances. In deciding whether to grant the insurer's request for a waiver, the commissioner may consider the type and volume of business written, ownership and organizational structure of the insurer and any other factors the commissioner considers relevant to the insurer or insurance group of which such insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than one state, the commissioner shall coordinate with the lead state commissioner, as determined by the procedures in NAIC's applicable financial analysis handbook, of such insurance group and with the other insurance regulatory officials of member insurers' states of domicile in considering whether to grant the insurer's request for a waiver.

(5) If an insurer that qualifies for an exemption pursuant to subdivision (1) of this subsection subsequently no longer qualifies for such exemption due to changes in premiums as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which such insurer is a member, such insurer shall have one year following the year the threshold is exceeded to comply with the requirements of subsections (b) to (e), inclusive, of this section.

(6) Notwithstanding the exemptions in this subsection, the commissioner may require that a domestic insurer comply with the requirements of subsections (b) to (e), inclusive, of this section: (A) Based on unique circumstances including, but not limited to, the type and volume of business written, ownership and organizational structure of the insurer and requests from a federal agency or the insurance regulatory official of a foreign jurisdiction; or (B) if the insurer (i) has risk-based capital for a company action level event, as set forth in sections 38a-72-1 to 38a-72-13, inclusive, and 38a-193-1 to 38a-193-13, inclusive, of the regulations of Connecticut state agencies, (ii) meets one or more of the standards of an insurer deemed to be in a hazardous financial condition, as set forth in section 38a-8-103 of the regulations of Connecticut state agencies, or (iii) otherwise exhibits qualities of a troubled insurer as determined by the commissioner.

(h) (1) All documents, materials or other information, including the ORSA Summary Report, in the possession or control of the Insurance Department that are obtained by, created by or disclosed to the commissioner or any other person pursuant to subsections (b) to (e), inclusive, or subsection (g) of this section shall be confidential by law and privileged, shall not be subject to disclosure under section 1-210 of the general statutes, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any civil action in this state. The commissioner may use such documents, materials or information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make such documents, materials or other information public without the prior written consent of the insurer.

(2) Neither the commissioner nor any person who, while acting under the authority of the commissioner, obtained or created documents, materials or other information pursuant to subsections (b) to (e), inclusive, or subsection (g) of this section, or to whom such documents, materials or other information were disclosed, through examination or otherwise, shall be permitted or required to testify in any civil action in this state concerning any such documents, materials or information.

(i) To assist the commissioner in the performance of the commissioner's regulatory duties, the commissioner:

(1) May share upon request documents, materials or other information set forth in subdivision (1) of subsection (h) of this section, including documents, materials or information deemed confidential and privileged or not disclosable pursuant to said subdivision (1), with (A) other state, federal and international regulatory officials, including members of a supervisory college as described in section 38a-135 of the general statutes, (B) NAIC, and (C) any third-party consultants designated by the commissioner, provided the recipient of any such documents, materials or other information agrees, in writing, to maintain the confidentiality and privileged status of such documents, materials or other information and has verified, in writing, the recipient's legal authority to maintain confidentiality, and further provided, the commissioner obtains the written consent of the insurer prior to sharing any such documents, materials or other information;

(2) May receive ORSA-related documents, materials or other information, including documents, materials or information deemed confidential and privileged, from regulatory officials of other states or foreign jurisdictions, including members of a supervisory college as described in section 38a-135 of the general statutes, and NAIC. The commissioner shall maintain as confidential and privileged any documents, materials or information received with notice or the understanding that such documents, materials or information are confidential and privileged under the laws of the jurisdiction that is the source of such documents, materials or information; and

(3) Shall enter into a written agreement with NAIC or a third-party consultant, governing the sharing and use of documents, materials and information shared or received pursuant to subsection (h) of this section. Any such agreement shall (A) specify procedures and protocols regarding the confidentiality and security of such documents, materials or other information that are shared with NAIC or a third-party consultant, including procedures and protocols limiting sharing by NAIC to only regulatory officials of states in which other member insurers of the insurance group of which a domestic insurer is a member are domiciled, including a requirement that any agreement shall provide that the recipient agrees in writing to maintain the

confidentiality and privileged status of the ORSA related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;(B) specify that the commissioner shall retain ownership of such documents, materials or other information and that the use of such documents, materials or other information is subject to the commissioner's discretion; (C) prohibit NAIC or the third-party consultant from storing such documents, materials or other information in a permanent database after the underlying analysis is completed; (D) require prompt notice to be given to an insurer whose confidential information is in the possession of NAIC or a third-party consultant if NAIC or the third-party consultant is subject to a request or subpoena for disclosure or production of such documents, materials or other information; and (E) require NAIC or the third-party consultant, if NAIC or such consultant is subject to disclosure of an insurer's confidential documents, materials or other information that has been shared with NAIC or such consultant pursuant to subsection (h) of this section, to allow such insurer to intervene in any judicial or administrative action regarding such disclosure.

(4) No waiver of any applicable privilege or claim of confidentiality in any documents, materials or other information thereof shall occur as a result of disclosure to the commissioner or of sharing in accordance with this subsection. Nothing in this subsection shall be construed to delegate any regulatory authority of the commissioner to any person or entity with which any documents, materials or other information thereof have been shared.

(5) The ORSA Summary Report and any related documents, materials or other information thereof in the possession or control of NAIC or a third-party consultant pursuant to this subsection shall be confidential by law and privileged, shall not be subject to disclosure under section 1-210 of the general statutes, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any civil action in this state.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID1101HoldingCompanyAct.doc

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Insurance Department

Liaison: Jim Perras
Phone: 860.297.3864
E-mail: jim.perras@ct.gov

Lead agency division requesting this proposal:
Connecticut Insurance Department / Financial Regulation Division

Agency Analyst/Drafter of Proposal:
Jon Arsenault

Title of Proposal
AAC Group-wide Supervision for Internationally Active Insurance Groups

Statutory Reference: CONN. GEN. STAT. § 38a-135

Proposal Summary

To amend the Insurance Holding Company System Regulatory Act, to authorize the Insurance Commissioner to serve as groupwide supervisor for any internationally active insurance group that has an insurer registered pursuant to Conn. Gen. Stat. § 38a-135 and has one or more non-U.S. insurance affiliates. As groupwide supervisor, the Commissioner is authorized to: access the enterprise risks with the group; request information necessary and appropriate for such assessment; compel development and implementation of reasonable measures to assure that the group is able to timely recognize and mitigate material risks to the insurers of the group; communicate and share relevant information with insurance regulatory officials within the group through supervisory colleges; enter into agreements with or obtain information from any registered insurer and any other member of the insurance group and other insurance regulatory officials for members of the group providing the basis for or otherwise clarifying the Commissioner's role as group supervisor, including provisions for resolving disputes with other relevant supervisory authorities.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

Reason for Proposal: To enhance the Insurance Commissioner's insurance group supervision authority to safeguard the financial security of insurance companies registered with the Commissioner as a member of an insurance holding company system that has one or more insurance affiliates domiciled outside of the U.S. The proposed amendment builds upon and complements the 2012 amendments to the Connecticut Insurance Holding Company Act to strengthen group supervision and oversight designed to identify and mitigate risk that could have a material adverse effect upon the financial condition or liquidity of a group insurer or the insurer's insurance holding company system as a whole.

Please consider the following, if applicable:

(1) *Have there been changes in federal/state/local laws and regulations that make this legislation necessary?* No.
(2) *Has this proposal or something similar been implemented in other states?* Yes. *If yes, what is the outcome(s)?* Improvements in the area of insurance group supervision.
(3) *Have certain constituencies called for this action?* __.
(4) *What would happen if this was not enacted in law this session?* We would seek its enactment in the next session.

- **Origin of Proposal** **X__ New Proposal** **__ Resubmission**

If this is a resubmission, please share: N/A

(1) *What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?*
(2) *Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?*
(3) *Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?*
(4) *What was the last action taken during the past legislative session?*

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: **No other agencies impacted.**
Agency Contact (name, title, phone): **N/A**
Date Contacted: **N/A**

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments
N/A

Will there need to be further negotiation? ___ YES **x** NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) **No fiscal impact.**

State

No fiscal impact.

Federal

No fiscal impact.

Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Insert fully drafted bill here

An Act Concerning Groupwide Supervision for Internationally Active Insurance Groups

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

Section 1. Section 38a-135 of the general statutes is amended by adding subsection (o) as follows *(Effective October 1, 2014)*:

(NEW) (o)(1) As used in this subsection: (A) "Groupwide supervisor" means the chief insurance regulatory official that is authorized to engage in groupwide supervision and is from the jurisdiction determined or acknowledged by the department to have sufficient significant contacts with the internationally active insurance group ; (B) "Internationally active insurance group" means any insurance holding company system that includes an insurer registered pursuant to section 38a-135 and one or more affiliates engaged in the business of insurance that are domiciled outside of a jurisdiction accredited by the NAIC.

(1) The Commissioner is authorized to act as a groupwide supervisor for any internationally active insurance group.

(2) The Commissioner may determine that the Commissioner is an appropriate groupwide supervisor for an internationally active insurance group, or may acknowledge that another chief insurance regulatory official is an appropriate groupwide supervisor for the internationally active insurance group. The relevant factors to be considered by the department when making a determination or acknowledgment under this section include:

(A) The place of legal residence of the ultimate controlling person of the internationally active insurance group.

(B) The place of origin of the insurance business of the members within the internationally active insurance group.

(C) The location of capital supporting the operations of the internationally active insurance group.

(D) The location of the insurance business operations supporting the internationally active insurance group.

(E) The location of employees of the insurance business operations within the internationally active insurance group.

(F) Whether another chief insurance regulatory official is acting or seeking to act as lead group supervisor under a regulatory system that the Commissioner determines to be substantially equivalent to that provided under the laws of the State of Connecticut or otherwise sufficient in terms of provision of groupwide supervision, enterprise risk analysis and cooperation with other chief regulatory officials, and whether that chief insurance regulatory official acting or seeking to act as lead group supervisor provides the department with mutual equivalency or sufficiency recognition.

(3) Pursuant to section 38a-14a, the Commissioner is authorized to collect from any insurer registered pursuant to section 38a-135 all information necessary to determine whether the Commissioner, or acknowledge whether another insurance regulatory official, may act as the

groupwide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to groupwide supervision by the Commissioner, the Commissioner shall notify the insurer registered pursuant to section 38a-135 and ultimate controlling person within the internationally active insurance group, and the internationally active insurance group shall have not less than 30 days to provide the Commissioner with additional information pertinent to the pending determination. The Commissioner shall publish the Insurance Department's website the identity of internationally active insurance groups that the Commissioner has determined are subject to groupwide supervision by the Commissioner.

(4) If the Commissioner is the groupwide supervisor for an internationally active insurance group, the Commissioner is authorized to engage in the following groupwide supervision activities:

(A) Assess, pursuant to section 38a-14a, the enterprise risks within the internationally active insurance group to ensure that material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management and to ensure that reasonable and effective mitigation measures are in place.

(B) Request from any member of an internationally active insurance group subject to the department's groupwide supervision information necessary and appropriate to assess enterprise risk, including, but not limited to, information about all members of the internationally active insurance group on governance, risk assessment and management, capital adequacy, and material intercompany transactions.

(C) Compel development and implementation of reasonable measures designed to assure that the internationally active insurance group is able to timely recognize and mitigate material risks to members of the internationally active insurance group that are engaged in the business of insurance.

(D) Communicate with insurance regulatory officials for members within the internationally active insurance group, and share relevant information, subject to the confidentiality provisions of section 38a-137, through supervisory colleges, as more fully set forth in subsection (n) of this section, or otherwise.

(E) Enter into agreements with or obtain documentation from any insurer registered under section 38a-135, and any other member of the internationally active insurance group, and other chief insurance regulatory officials for members of the internationally active insurance group, providing the basis for or otherwise clarifying the Commissioner's role as group supervisor, including provisions for resolving disputes with other relevant supervisory authorities. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not incorporated in the State of Connecticut is doing business in the state or is otherwise subject to jurisdiction in the state.

(5) If the Commissioner acknowledges that a regulatory official from a jurisdiction not accredited by the NAIC is the groupwide supervisor, the Commissioner is authorized to reasonably cooperate, through supervisory colleges or otherwise, with group supervision undertaken by the groupwide supervisor, provided that the Commissioner's cooperation is in compliance with the laws of this state and provided that the regulator also recognizes and cooperates with the Commissioner's activities as a groupwide supervisor for other internationally active insurance groups where applicable. Where such recognition and cooperation is not reasonably reciprocal, the Commissioner is authorized to refuse recognition and cooperation. The Commissioner is authorized to enter into agreements with or obtain documentation from any insurer registered under section 38a-135, and any affiliate of the insurer, and other regulatory officials for members of the insurance group, providing the basis for or otherwise clarifying a regulatory official's role as group supervisor.

(6) The Commissioner may adopt regulations, in accordance with Chapter 54, as necessary for the administration of this section. In determining whether any regulation should be promulgated, the Commissioner shall give due consideration to, among other things, model laws, model regulations, definitions or guidelines pertaining to groupwide supervision, if any, promulgated by the NAIC or other recognized insurance regulatory bodies or associations.

(7) A registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the Commissioner's participation in the administration of this section, including the engagement of attorneys, actuaries and any other professionals, and all reasonable travel expenses.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID1101PortOfEntry.doc

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Insurance Department

Liaison: Jim Perras
Phone: 860.297.3864
E-mail: jim.perras@ct.gov

Lead agency division requesting this proposal:
Connecticut Insurance Department / Financial Regulation Division

Agency Analyst/Drafter of Proposal:
Jon Arsenault

Title of Proposal
AAC Connecticut as a State of Entry of Alien Insurance Companies

Statutory Reference: **New**

Proposal Summary

To amend the insurance statutes to provide the requirements for Connecticut to serve as a state of entry for non-U.S. insurers to transact the business of insurance through an authorized U.S. branch rather than through a separately incorporated subsidiary. Sec. 1 contains definitions. Sec. 2 makes it clear that the Act applies to a U.S. branch of a non-U.S. insurer and it shall be subject to all applicable state laws for domiciled insurers unless stated otherwise. Sec. 3 Authorizes a non-U.S. insurer to use Connecticut as a state of entry by first qualifying as an insurer licensed to do business in this state, establishing a trust account with a U.S. financial institution with the amount deposited in the trust equal at least to the minimum capital and surplus require to be maintained by a domestic insurers, and submit to an examination of its affairs. Sec. 4 provides that the assets of the trust account shall at all times be in an amount equal to the greater of reserves and other liabilities plus the minimum capital and surplus or authorized control level risk-based capital. Sec. 5 specifies the requirements for the trust account. Sec. 6 specifies the financial reporting requirements for the U.S. branch. Sec. 7 specifies additional requirements for a U.S. branch license. Sec. 8 provides for the authority of Commissioner when branch is operating in a hazardous financial condition. Sec. 9 provides for the domestication of a U.S. branch of a non-U.S. insurer as a Connecticut domestic insurance company.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

Reason for Proposal: To promote Connecticut's economy in the financial services insurance sector by authorizing non-U.S. insurers to enter the U.S. and to transact the business of insurance through the establishment of a U.S. branch in Connecticut. The legislation in based on the NAIC State of Entry Model Law.

Please consider the following, if applicable:

(1) *Have there been changes in federal/state/local laws and regulations that make this legislation necessary?* No.
(2) *Has this proposal or something similar been implemented in other states?* Yes. *If yes, what is the outcome(s)?* Improvements in the area of insurance group supervision.
(3) *Have certain constituencies called for this action?* Yes
(4) *What would happen if this was not enacted in law this session?* We would seek its enactment in the next session. May lose opportunity to other states with existing port of entry law.

- **Origin of Proposal** **X__ New Proposal** **__ Resubmission**

If this is a resubmission, please share: N/A

(1) *What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?*
(2) *Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?*
(3) *Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?*
(4) *What was the last action taken during the past legislative session?*

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: **No other agencies impacted.**
Agency Contact (name, title, phone): **N/A**
Date Contacted: **N/A**

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments
N/A

Will there need to be further negotiation? ___ YES __x__ NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) **No fiscal impact.**

State
Financial Regulation Division of the Insurance Department would need to assess the industry for one additional analyst position and one additional examiner position. Costs would be contrasted by new revenue to the state from new branch openings.

Federal

No fiscal impact.

Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

This proposal reflects the administration's call for state government to be more flexible and accommodating to business by giving insurance companies another avenue for entering into the U.S. market.

Insert fully drafted bill here

AN ACT CONCERNING CONNECTICUT AS A STATE OF ENTRY OF ALIEN INSURANCE COMPANIES

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

Section 1. (NEW) (*Effective from passage*) **Definitions.** As used in sections 1 to 9, inclusive, of this act:

(1) "Alien insurer" has the same meaning as provided in section 38a-1.

(2) "Authorized Control Level Risk Based Capital" means the number determined under the risk-based capital formula in accordance with the provisions of subsection (d) of section 38a-72 and the regulations adopted pursuant thereto.

(3) "Commissioner" means the Insurance Commissioner.

(4) "Domestication" means the reorganization of the United States branch of an alien insurer as the result of which a domestic insurer shall succeed to all the business and assets and assume all the liabilities of the United States branch of the alien insurer.

(5) "State" means any state, commonwealth, territory or possession of the United States and the District of Columbia.

(6) "Trusteed assets" mean the assets in a trust account required by section 4 of this act.

(7) "Trusteed surplus" means the aggregate value of the alien insurer's general state deposits and trusteed assets deposited with a trustee in compliance with section 5 of this act, plus accrued investment income thereon where such interest is collected by the states for trustees, less the aggregate net amount of all of the insurer's reserves and other liabilities in the United States as determined in accordance with section 6 of this act.

(8) "United States" means the several states, commonwealths, territories and possessions of the United States of America and the District of Columbia.

(9) "United States branch" means the business unit through which business is transacted within the United States by an alien insurer and the assets and liabilities of

the insurer within the United States pertaining to such business.

Sec. 2. (NEW) (*Effective from passage*) **Scope.** This act applies to a United States branch using this State as a state of entry to transact insurance in the United States. The United States branch shall be subject to all state laws applicable to an insurer domiciled in this State, including sections 38a-47 and 38a-48, unless otherwise provided.

Sec. 3. (NEW) (*Effective from passage*) **Authorization of entry.** (a) An alien insurer may use this State as a state of entry to transact insurance in the United States through a United States branch by:

(1) Qualifying as an insurer licensed to do business in this State; and

(2) Establishing trust accounts, pursuant to trust agreements approved by the Commissioner with a United States financial institution as defined in section 38a-87, in an amount at least equal to the minimum capital and surplus or authorized control level risk-based capital, whichever is greater, required to be maintained by a domestic insurer licensed for the same kind of insurance.

(b) Before authorizing the entry of a United States branch of any alien insurer through this State, the Commissioner shall in addition to the requirements of section 5 of this act and any other requirement of the insurance law, require the alien insurer to:

(1) Comply with the requirements of section 38a-41;

(2) Submit an English language translation, as necessary, of any of the documents required in paragraph (1); and

(3) Submit to an examination of the insurer's affairs at its principal office within the United States; provided however, the Commissioner in his or her discretion may accept a report of the insurance supervisory official of the insurer's home jurisdiction.

Sec. 4. (NEW) (*Effective from passage*) **Maintenance of Trust Account.** The trusteed assets, or the assets of the trust account of an alien insurer, as required by section 3 of this act, shall at all times be in an amount equal to the United States branch's reserves and other liabilities plus the minimum capital and surplus or authorized control level risk-based capital, whichever is greater, required to be maintained by a domestic insurer licensed to do the same kind of insurance.

Sec. 5. (NEW) (*Effective from passage*) **Requirements for Trust Agreement.** (a) The terms of the trust agreement required by section 3 of this act shall be set forth in a deed of trust. The deed of trust and all subsequent amendments shall be authenticated in a form and manner as the Commissioner may prescribe and shall not be effective unless approved by the Commissioner upon a finding that:

(1) A deed of trust or its amendments are sufficient in form and in conformity with law;

(2) The trustee or trustees are eligible as such; and

(3) The deed of trust is adequate to protect the interests of the beneficiaries of the trust.

(b) If at any time after reasonable notice and hearing, the Commissioner finds that the requisites for the approval no longer exist, the Commissioner may withdraw approval.

(c) The Commissioner may approve modifications of, or variations in any deed of trust, which in the Commissioner's judgment are not prejudicial to the interests of the people of this State or policyholders and creditors in the United States, of the United States branch.

(d) The deed of trust shall contain provisions that:

(1) Vest legal title to trusteed assets in the trustee or trustees, and their lawfully appointed successors;

(2) Require that all assets deposited in the trust shall be continuously kept within the United States;

(3) Provide for substitution of a new trustee or trustees in case of a vacancy by death, resignation, or otherwise, subject to the approval of the commissioner;

(4) Require that the trustee or trustees shall continuously maintain a record at all times sufficient to identify the assets of such fund;

(5) Require that the trusteed assets shall consist of cash or investments, or both, as eligible for investment of the funds of domestic insurers and accrued interest thereon if collectable by the trustee;

(6) Require that the trust shall be for the exclusive benefit, security, and protection of the policyholders, or policyholders and creditors in the United States, of the United States branch;

(7) Require that the trust shall be maintained as long as there is any outstanding liability of the alien insurer arising out of its insurance transactions in the United States; and

(8) Provide, in substance, that no withdrawals of assets, other than income as specified in subsection (e) shall be made or permitted by the trustee or trustees without the approval of the commissioner except to:

(A) Make deposits required by law in any state for the security or benefit of all policyholders, or policyholders and creditors in the United States, of the United States branch;

(B) Substitute other assets permitted by law and at least equal in value and quality to those withdrawn, upon the specific written direction of the United States branch manager when duly empowered and acting pursuant to either general or specific written authority previously given or delegated by the board of directors; or

(C) Transfer such assets to an official liquidator or rehabilitator pursuant to an order of a court of competent jurisdiction.

(e) The deed of trust may provide that income, earnings, dividends, or interest accumulations of the assets of the fund may be paid over to the United States branch manager of the United States branch upon request; provided that the total trusteed assets shall not be less than the amount required to be maintained pursuant to section 4 of this act.

(f) Upon withdrawal of trusteed assets deposited in another state in which the insurer is authorized to do business, it shall be sufficient if the deed of trust requires similar written approval of the insurance supervising official of that state in lieu of approval of the Commissioner provided that the total trusteed assets shall not be less than the amount required to be maintained pursuant to Section of this act. In all such cases, the United States branch shall notify the Commissioner in writing of the nature and extent of the withdrawal.

(g) The Commissioner may:

(1) Make examinations of the trusteed assets of any authorized United States branch at the insurer's expense; and

(2) Require the trustee or trustees to file a statement, in such form as the Commissioner may prescribe, certifying the assets of the trust fund and the amounts thereof.

(h) Refusal or neglect of any trustee to comply with this section shall be grounds for the revocation of the insurer's license or the liquidation of its United States branch.

Sec. 6. (NEW) (*Effective from passage*) **Reporting Requirement for U.S. Branches of Alien Insurers.** (a) In addition to other requirements of this act and other applicable statutes of Title 38a, every authorized United States branch shall, not later than the first day of March in each year and forty-five days after the end of each of the first three calendar-year quarters, file with the Commissioner and with the National Association of Insurance Commissioners:

(1) Annual and quarterly statements of the business transacted within the United States and the assets held by or for it within the United States for the protection of policyholders and creditors within the United States, and of the liabilities incurred against such assets. The forms shall not contain any statement in regard to its assets and business elsewhere. The statements shall be in the same format required of an insurer domiciled in Connecticut and licensed to write the same kinds of insurance; and

(2) A statement of trusteed surplus, in such form as the Commissioner may prescribe, as of the end of the same period covered by the statement filed pursuant to subdivision (1) of this subsection. In determining the net amount of the United States branch's liabilities in the United States to be reported in the statement of trusteed surplus, the United States branch shall make adjustments to total liabilities reported on the accompanying annual or quarterly statement as follows:

(A) Add back liabilities used to offset admitted assets reported in the accompanying quarterly or annual statement; and

(B) Deduct:

(i) Unearned premiums on agent's balances or uncollected premiums not more than ninety days past due not exceeding unearned premium reserves carried thereon;

(ii) Reinsurance on losses with authorized insurers, less unpaid reinsurance premiums;

(iii) Reinsurance recoverables on paid losses from unauthorized insurers that are included as assets in the annual or quarterly statement; but only to the extent a liability for such unauthorized recoverables is included in the liabilities report in the trusteed surplus statement;

(iv) Special state deposits held for the exclusive benefit of policyholders, or policyholders and creditors, of any particular state not exceeding net liabilities reported

for that state;

(v) Secured accrued retrospective premiums;

(vi) If a life insurer, the amount of its policy loans to policyholders within the United States, not exceeding the amount of legal reserve required on each such policy;

(vii) If a life insurer, the net amount of uncollected and deferred premiums; and

(viii) Any other non-trusteed asset that the Commissioner determines secures liabilities in a substantially similar manner; and

(3) Provide any additional information that the Commissioner may require relating to the total business or assets, or any portion thereof, of the alien insurer.

(b) The annual statement and trusteed surplus statement shall be signed and verified by the United States branch manager, attorney-in-fact, or a duly empowered assistant United States branch manager, of the United States branch. The items of securities and other property held under trust deeds shall be certified in the trusteed surplus statement by the United States trustee or trustees.

(c) Every report on examination of a United States branch shall include a trusteed surplus statement as of the date of examination in addition to the general statement of the financial condition of the United States branch.

Sec. 7. (NEW) (*Effective from passage*) **Additional Requirements for United States Branch License.** (a) Before issuing any new or renewal license to any United States branch, the Commissioner may require satisfactory proof, either in the alien insurer's charter or by an agreement evidenced by a duly certified resolution of its board of directors, or otherwise as the Commissioner may require, that the insurer will not engage in any insurance business in contravention of this section or not authorized by its charter.

(b) The Commissioner shall issue a renewal license to any United States branch if satisfied, by such proof as required, that the insurer is not delinquent with respect to any requirement imposed by this act and that its continuance in business in this State will not be hazardous or prejudicial to the best interests of the people of this State.

(c) No United States branch shall be licensed to do any kind of insurance business in this State, or any combination of kinds of insurance business, that are not permitted to be done by domestic insurers licensed to do business under section 38a-41. No United States branch shall be authorized to do an insurance business in this State if it does anywhere within the United States any kind of business other than an

insurance business and the business necessarily or properly incidental to the kind or kinds of insurance business that it is authorized to do in this State.

(d) Except as otherwise specifically provided, no United States branch, entering through this State or another state, shall be or continue to be authorized to do an insurance business in this State if it fails to comply substantially with any requirement or limitation of this act, applicable to similar domestic insurers hereafter organized, which in the judgment of the Commissioner is reasonably necessary to protect the interest of the policyholders.

(e) No United States branch that, outside of this State, does any kind or combination of kinds of insurance business not permitted to be done in this State by similar domestic insurers hereafter organized, shall be or continue to be authorized to do an insurance business in this State, unless in the judgment of the Commissioner the doing of that kind or combination of kinds of insurance business will not be prejudicial to the best interests of the people of this State.

(f) No United States branch shall be or continue to be authorized to do an insurance business in this State if it fails to keep full and correct entries of its transactions, which shall at all times be open to the inspection of persons invested by law with the rights of inspection and be maintained in its principal office within this State.

Sec. 8. (NEW) (*Effective from passage*) **Authority of Commissioner.** Whenever it appears to the Commissioner from any annual statement, quarterly statement, trusteed surplus statement, or any other report that a United States branch's trusteed surplus is reduced below minimum capital and surplus or the authorized control level risk-based capital, whichever is greater, required to be maintained by a domestic insurer licensed to transact the same kinds of insurance, the Commissioner may proceed against the insurer pursuant to the provisions of chapter 704c as an insurer whose condition is such that its further transaction of business in the United States will be hazardous to its policyholders, its creditors, or the public in the United States.

Sec. 9. (NEW) (*Effective from passage*) **Domestication of Alien Insurer.**

(a) **Domestication procedure.** Upon compliance with the provisions of this section any alien company authorized to do business in this State may, with the prior written approval of the Commissioner, domesticate its United States branch by entering into an agreement in writing with a domestic company providing for the acquisition by the domestic company of all of the assets and the assumption of all of the liabilities of the United States branch. The acquisition of assets and assumption of liabilities of the

United States branch by the domestic company shall be effected by filing with the Director an instrument of transfer and assumption in form satisfactory to the Commissioner and executed by the alien company and the domestic company.

(b) **Domestication agreement.** (1) The domestication agreement referred to in subsection (a) of this section shall be authorized, adopted, approved, signed, and acknowledged by the alien company in accordance with the laws of the country under which it is organized. In the case of a domestic company, the domestication agreement shall be approved, adopted, and authorized by its board of directors and executed by its president or any vice president and attested by its secretary or assistant secretary under its corporate seal.

(c) **Commissioner's approval of agreement.** An executed counterpart of the domestication agreement, together with certified copies of the corporate proceedings of the domestic company and the alien company, approving, adopting and authorizing the execution of the domestication agreement, shall be submitted to the Commissioner for approval. The Commissioner shall thereupon consider the agreement, and, if the Commissioner finds that the same is in accordance with the provisions hereof and that the interests of policyholders of the United States branch of the alien insurer and of the domestic company are not materially adversely affected, the Commissioner shall approve the domestication agreement and authorize the consummation thereof in compliance with the provisions of subsection (d) of this section. The Commissioner shall approve or disapprove the domestication agreement within sixty days after it is submitted to the Commissioner.

(d) **Consummation of domestication; transfer of assets and deposits.** (1) Upon the filing with the Commissioner of a certified copy of the instrument of transfer and assumption pursuant to which a domestic company succeeds to the business and assets of the United States branch of an alien company and assumes all its liabilities, the domestication of the United States branch shall be deemed to be effective; and thereupon all the rights, franchises, and interests of the United States branch in and to every species of property, real, personal, and mixed, and things in actions thereunder belonging shall be deemed as transferred to and vested in the domestic company, and simultaneously therewith the domestic company shall be deemed to have assumed all of the liabilities of the United States branch. The domestic company shall be considered as having the age as the oldest of the two parties to the domestication agreement for purposes of complying with the requirements of laws relating to age of company.

(2) All deposits of the United States branch held by the Commissioner, or by state officers or other state regulatory agencies pursuant to requirements of state laws,

shall be deemed to be held as security for the satisfaction by the domestic company of all liabilities to policyholders within the United States assumed from the United States branch; and such deposits shall be deemed to be assets of the domestic company and shall be reported as such in the annual financial statements and other reports which the domestic company may be required to file. Upon the ultimate release by any such state officer or agency of any such deposits, the securities and cash constituting such released deposit shall be delivered and paid over to the domestic company as the lawful successor in interest to the United States branch.

(3) Contemporaneously with the consummation of the domestication of the United States branch, the Commissioner shall direct the trustee, if any, of the U.S. branch's Trusteed Assets to transfer and deliver to the domestic company all assets, if any, held by such trustee.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID1101Captives.doc

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Insurance Department

Liaison: Jim Perras
Phone: 860.297.3864
E-mail: jim.perras@ct.gov

Lead agency division requesting this proposal:
Connecticut Insurance Department / Captives Division

Agency Analyst/Drafter of Proposal:
John Thomson / Jon Arsenault

Title of Proposal
AAC Adjustments to the Captive Statutes

Statutory Reference: CONN. GEN. STAT. §§ 38a-91bb, 38a-91ff, 38a-91kk and 38a-91oo.

Proposal Summary

To revise portions of the captive insurance law to facilitate the process of captives forming in or transferring their domicile to Connecticut, promote effective corporate governance and harmonize the references in the captive insurance law with statutory provisions defining personal risk insurance and commercial risk insurance.

Sec. 1. Amends subsection (5) of section 38a-91bb(a), to specifically reference the definition of personal risk insurance found in 38a-663.

Sec. 2. Amends subsection (n) of section 38a-91ff and section 38a-58a to add provisions governing the transfer of domicile.

Sec. 3. Amends subsection (b) of section 38a-91kk to permit the Insurance Commissioner to give prior approval to captive insurance companies seeking credit for reinsurance when the transaction does not meet the requirements of 38a-85 to 38a-88, inclusive.

Sec. 4. Amends section 38a-91oo to make the application of 38a-73 and 38a-129 to 38a-140, inclusive, discretionary, rather than mandatory, with respect to captive insurance companies other than risk retention groups, adds restrictions regarding the use of special knowledge or information and adds references to provisions governing transfer of domicile.

Sec.5. Amends subsection (e) of section 38a-91ff to remove a limitation on the types of

business which can be written by a branch captive.

Sec. 6 Amends subsection (a) of section 38a-58a to facilitate a transfer of domicile for captive insurers.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) *Have there been changes in federal/state/local laws and regulations that make this legislation necessary?* **No.**

(2) *Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?* **The Connecticut Captive Insurance Law is modeled off similar laws in Vermont.**

(3) *Have certain constituencies called for this action?* **Yes. Captive insurers in the process of transferring their domicile or considering either formation or transfer have pointed out the need for these changes.**

(4) *What would happen if this was not enacted in law this session?* **Captive insurers might decide against domesticating their business here. This could lead them to domesticate in a state with a laws that reflect more proportional and tailored approach to regulation.**

- **Origin of Proposal** ___ **New Proposal** _X_ **Resubmission**

If this is a resubmission, please share:

(1) *What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?* ***In the 2013 session it was submitted to the legislature as part of the Department's Technical Revisions bill SB 1093. It passed the Senate unanimously and died on the House calendar.***

(2) *Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?* **NO**

(3) *Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?* ***Sen. Crisco is a big proponent of developing our captive industry, we also received lots of support from the Connecticut Captive Insurance Association***

(4) *What was the last action taken during the past legislative session?* ***It passed the Senate unanimously and died on the House calendar.***

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: **No other agencies impacted.**
Agency Contact (name, title, phone): **N/A**
Date Contacted: **N/A**

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

N/A

Will there need to be further negotiation? ___ YES __x__ NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) **No fiscal impact.**
State **No fiscal impact.**
Federal
Additional notes on fiscal impact If more companies domicile in Connecticut as a result of this legislation, it will have a positive fiscal impact by increasing premium tax revenue.

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Could increase the number of Captive companies that domicile in Connecticut therefore increasing premium tax revenue while simultaneously enhancing Connecticut's image as the "insurance capitol of the world".

Insert fully drafted bill here

Section 1. Subsection (5) of 38a-91bb of the general statutes is repealed and the following is substituted in lieu thereof *(Effective TBD, 2014)*:

(5) No captive insurance company may provide personal risk insurance, as defined in section 38a-663, for private passenger motor vehicle or homeowners insurance coverage or any component thereof;

Section 2. Subsection (n) of 38a-91ff of the general statutes is repealed and the following is substituted in lieu thereof *(Effective TBD, 2014)*:

(n) The provisions of this chapter pertaining to mergers, consolidations, transfer of domicile and conversions shall apply in determining the procedures to be followed by captive insurance companies in carrying out any of the transactions described in this chapter.

Section 3. Subsection (b) of 38a-91kk of the general statutes is repealed and the following is substituted in lieu thereof *(Effective TBD, 2014)*:

(b) A captive insurance company may only take credit for the reinsurance of risks or portions of risks ceded to reinsurers that complies with the provisions of 38a-85 [or 38a-86] to 38a-88, inclusive, unless the commissioner has given prior written approval allowing the captive insurance company to take credit with respect to the reinsurance of a risk or portion of risk that does not comply with the provisions of 38a-85 to 38a-88, inclusive.

Section 4. Section 38a-91oo of the general statutes is repealed and the following is substituted in lieu thereof *(Effective TBD, 2014)*:

(a) Unless otherwise provided in sections 38a-91aa to 38a-91tt, inclusive, no provision of this title shall apply to captive insurance companies, unless expressly included therein, except for the following: Sections 38a-8, 38a-16, 38a-17, 38a-54 to [38a-57, inclusive,] 38a-59, inclusive, 38a-69a, [38a-73, 38a-129 to 38a-140, inclusive, and] 38a-102h, 38a-250 to 38a-266, inclusive, and chapter 704c.

(b) Risk retention groups shall be subject to and the commissioner may subject other types of captive insurance companies to the provisions of sections 38a-73 and 38a-129 to 38a-140, inclusive.

Section 5. Subsection (e) of Section 38a-91ff of the general statutes is repealed and the following is substituted in lieu thereof (Effective TBD, 2014):

(e) [A branch captive insurance company may be established in this state to write in this state only insurance or reinsurance of the employee benefit business of its parent and affiliated companies that is subject to the Employee Retirement Income Security Act of 1974, as amended from time to time.] No branch captive insurance company shall do any insurance business in this state unless it maintains [the principal] a place of business for its branch operations in this state.

Section 6. Subsection (a) of Section 38a-58a of the general statutes is repealed and the following is substituted in lieu thereof (Effective TBD, 2014):

(a) Any insurer which is organized under the laws of any other state and is admitted to do business in this state for the purpose of writing insurance may become a domestic insurer by complying with all of the requirements of law relative to

the organization and licensing of a domestic insurer of the same type and by designating its principal place of business at a location in this state. A captive insurance company, as defined in Section 38a-91aa, which is organized under the laws of any other state may become a domestic insurer by complying with all of the requirements of law relative to the organization and licensing of a domestic insurer of the same type and by designating its principal place of business at a location in this state. The domestic insurer shall be entitled to like certificates and licenses to transact business in this state and shall be subject to the authority and jurisdiction of this state. The articles of incorporation of the domestic insurer may be amended to provide that the corporation is a continuation of the corporate existence of the original foreign corporation through adoption of this state as its corporate domicile and that the original date of incorporation in its original domiciliary state is the date of incorporation of the domestic insurer.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID1101FinancialRegulationsRevisions.doc

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Insurance Department

Liaison: Jim Perras
Phone:860.297.3864
E-mail:Jim.Perras@ct.gov

Lead agency division requesting this proposal:
Financial Regulation

Agency Analyst/Drafter of Proposal:
Beth Cook

Title of Proposal
AAC Financial Regulation of Insurers

Statutory Reference

Proposal Summary

Sec. 1, 10, 11, &12. New to create a new category of insurer – the domestic surplus lines insurer. Amend statutes 38a-1, 38a-712, 38a-794 to align with the new category.

Sec. 2 Amend 38a-11 to enact a $3000 fee for filing a Form A Change of Control Application and a $2000 fee to review clinical review criteria vendor applications pursuant to 38a-591c

Sec. 3. Amend the financial examination statute (38a-14) to include a provision requiring that the Board of Directors of examined companies receive and review exam reports and provide documentation of such review for their corporate files which are subject to audit and review by the Department

Sec. 4 Amend 38a-53 to provide the Commissioner discretion to waive a late filing fees for quarterly and annual financial statements when the domiciliary regulator has waived such filings or approved filing delays in defined situations

Sec. 5 – amend 38a-85 to align statute with NAIC Model relating to which commissioner has principle authority over an assuming insurers trust to permit reductions in trusteed assets under the credit for reinsurance statute

Sec. 6 - amend 38a-136(b)(1)(C)and (D) to mirror NAIC Holding Company Model for purposes of accreditation for 1/1/16.

Sec. 7&8. Amend 38a-162 to increase license fees for Premium Finance Companies

Sec. 9 Amend 38a-188 to extend exam authority to health care centers

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

Sec. 1, 10, 11, &12. New to create a new category of insurer – the domestic surplus lines insurer. Amend statutes 38a-1, 38a-712, 38a-794 to align with the new category. Current statutes permit surplus lines brokers to place business with eligible surplus lines insurers. These insurers are not authorized to do business in CT, but are required to be authorized to do business in their domiciliary jurisdiction. This prevents a surplus lines insurer from writing surplus lines business in their domiciliary state even on multi-state risks where the risk is not entirely within the insurer's domicile state.

Sec. 2. Amend 38a-11 to enact a $3000 fee for filing a Form A (Change of Control) Application – these filings consume considerable staff resources and while most go forward to completion, some do get withdrawn after significant resources have been expended – a filing fee is consistent with how many other states require similar fees. Amend 38a-11 to enact a $2000 fee for seeking approval by the Commissioner as a qualified clinical review criteria vendor for purposes of 38a-591c. This will cover the cost of a medical consultant if needed to review the criteria.

Sec. 3. Amend the financial examination statute (38a-14) to include a provision requiring that the Board of Directors of examined companies receive and review exam reports and provide documentation of such review for their corporate files which are subject to audit and review by the Department – to engage the governing body of a company that has been examined

Sec. 4 Amend 38a-53 to provide the Commissioner discretion to waive a late filing fees for quarterly and annual financial statements when the domiciliary regulator has waived such filings or approved filing delays in defined situations – to provide for the Commissioner to use his discretion to waive late fees when the insurance regulator of the domicile state of foreign insurers has waived or approved a delay for filing requirements; increase late fees for fraternals on par with insurers and health care centers

Sec. 5 – Amend 38a-85 to align statute with NAIC Model relating to which commissioner has principle authority over an assuming insurers trust to permit reductions in trusteed assets under the credit for reinsurance statute

Sec.6 amend 38a-136(b)(1)(C)and (D) to mirror NAIC Holding Company Model for purposes of accreditation for 1/1/16.

Sec. 7&8. Amend 38a-162 to increase license fees for Premium Finance Companies – brings this license fee into parity with general business corporation licenses in CT

Sec. 9 Amend 38a-188 to extend exam authority to health care centers – codifies the explicit authority to examine these companies

- **Origin of Proposal** **__x_ New Proposal** **___ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency) ---- No other agencies affected

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) n/a
State insignificant – State may receive some additional revenue because of increased fees, but these should not be significant; we currently license 40 premium finance companies which will provide an additional annual revenue gain of $10,000 through the increased fee; Form A fees are sporadic and would likely not generate more that $5000 in any single year; filing fee waivers are expected to be minimal and will not significantly lessen what is already a minimal revenue source
Federal n/a
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Sec. 1, 10, 11, 12. New to create a new category of insurer – the domestic surplus lines insurer. Amend statutes 38a-1, 38a-712, 38a-794 to align with the new category. Sec. 2. Amend 38a-11 to enact a $3000 fee for filing a Form A (Change of Control) Application – introduce a filing fee for Form As. Amend 38a-11 to enact $2000 fee to review application to become qualified clinical review criteria vendor. Sec.3. Amend the financial examination statute (38a-14) to include a provision requiring that the Board of Directors of examined companies receive and review exam reports and provide documentation of such review for their corporate files which are subject to audit and review by the Department – requires Financial Regulation to distribute the report to the examined company's Board members

Sec. 4 Amend 38a-53 to provide the Commissioner discretion to waive a late filing fees for quarterly and annual financial statements when the domiciliary regulator has waived such filings or approved filing delays in defined situations – permits waiver under defined conditions; increase fraternal late fee on par with insurers and health care centers

Sec. 5 – amend 38a-85 to align statute with NAIC Model relating to which commissioner has principle authority over an assuming insurers trust to permit reductions in trusteed assets under the credit for reinsurance statute

Sec. 6 amend 38a-136(b)(1)(C)and (D) to mirror NAIC Holding Company Model for purposes of accreditation for 1/1/16.

Sec. 7&8. Amend 38a-162 to increase license fees for Premium Finance Companies – minimal revenue impact

Sec. 9 Amend 38a-188 to extend exam authority to health care centers – already performing exams; this codifies the explicit authority – no resource impact change

AN ACT CONCERNING REVISIONS TO THE INSURANCE STATUTES.

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

Section 1. Section 38a-1 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

Terms used in this title, unless it appears from the context to the contrary, shall have a scope and meaning as set forth in this section.

(1) "Affiliate" or "affiliated" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with another person.

(2) "Alien insurer" is defined in subparagraph (A) of subdivision (11) of this section.

(3) "Annuities" means all agreements to make periodical payments where the making or continuance of all or some of the series of the payments, or the amount of the payment, is dependent upon the continuance of human life or is for a specified term of years. This definition does not apply to payments made under a policy of life insurance.

(4) "Commissioner" means the Insurance Commissioner.

(5) "Control", "controlled by" or "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with the person.

(6) "Domestic insurer" is defined in subparagraph (B) of subdivision (11) of this section.

(7) "Foreign country" means any jurisdiction not in any state, district or territory of the United States.

(8) "Foreign insurer" is defined in subparagraph (C) of subdivision (11) of this section.

(9) "Insolvency" or "insolvent" means, for any insurer, that it is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of: (A) Capital and surplus required by law for its organization and continued operation; or (B) the total par or stated value of its authorized and issued capital stock. For purposes of this subdivision "liabilities" shall include but not be limited to reserves required by statute or by regulations adopted by the commissioner in accordance with the provisions of chapter 54 or specific requirements imposed by the commissioner upon a subject company at the time of admission or subsequent thereto.

(10) "Insurance" means any agreement to pay a sum of money, provide services or any other thing of value on the happening of a particular event or contingency or to provide indemnity for loss in respect to a specified subject by specified perils in return for a consideration. In any contract of insurance, an insured shall have an interest which is subject to a risk of loss through destruction or impairment of that interest, which risk is assumed by the insurer and such assumption shall be part of a general scheme to distribute losses among a large group of persons bearing similar risks in return for a ratable contribution or other consideration.

(11) "Insurer" or "insurance company" includes any person or combination of persons doing any kind or form of insurance business other than a fraternal benefit society, and shall include a receiver of any insurer when the context reasonably permits. When modified as follows, the term has the following meanings:

(A) "Alien insurer" means any insurer that has been chartered by or organized or constituted within or under the laws of any state or country without the United States.

(B) "Domestic insurer" means any insurer that has been chartered by, incorporated, organized or constituted within or under the laws of this state.

(C)["Foreign insurer" means any insurer that has been chartered by or organized or constituted within or under the laws of another state or a territory of the United States.] "Domestic surplus lines insurer" means a domestic insurer that has been chartered by, incorporated, organized or constituted within or under the laws of this state and which has been declared to be an eligible surplus lines insurer by the commissioner. Such insurer shall be deemed a nonadmitted insurer under the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203, as amended from time to time.

(D) "Foreign insurer" means any insurer that has been chartered by or organized or constituted within or under the laws of another state or a territory of the United States.

[(D)](E) "Mutual insurer" means any insurance company without capital stock, the managing directors or officers of which are elected by its members.

[(E)](F) "Unauthorized insurer" or "nonadmitted insurer" means (i) an insurer that has not been granted a certificate of authority by the commissioner to transact the business of insurance in this state or an insurer transacting business not authorized by a valid certificate or, (ii) a domestic surplus lines insurer .

(12) "Insured" means a person to whom or for whose benefit an insurer makes a promise in an insurance policy. The term includes policyholders, subscribers, members and beneficiaries. This definition applies only to the provisions of this title and does not define the meaning of this word as used in insurance policies or certificates.

(13) "Life insurance" means insurance on human lives and insurances pertaining to or connected with human life. The business of life insurance includes granting endowment benefits, granting additional benefits in the event of death by accident or accidental means, granting additional benefits in the event of the total and permanent disability of the insured, and providing optional methods of settlement of proceeds. Life insurance includes burial contracts to the extent provided by section 38a-464.

(14) "Person" means an individual, a corporation, a partnership, a limited liability company, an association, a joint stock company, a business trust, an unincorporated organization or other legal entity.

(15) "Policy" means any document, including attached endorsements and riders, purporting to be an enforceable contract, which memorializes in writing some or all of the terms of an insurance contract.

(16) "State" means any state, district, or territory of the United States.

(17) "Subsidiary" of a specified person means an affiliate controlled by the person directly, or indirectly through one or more intermediaries.

(18) "Unauthorized insurer" is defined in subparagraph (E) of subdivision (11) of this section.

(19) "United States" means the United States of America, its territories and possessions, the Commonwealth of Puerto Rico and the District of Columbia.

Sec. 2. Subsection (a) of section 38a-11 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) The commissioner shall demand and receive the following fees: (1) For the annual fee for each license issued to a domestic insurance company, two hundred dollars; (2) for receiving and filing annual reports of domestic insurance companies, fifty dollars; (3) for filing all documents prerequisite to the issuance of a license to an insurance company, two hundred twenty dollars, except that the fee for such filings by any health care center, as defined in section 38a-175, shall be one thousand three hundred fifty dollars; (4) for filing any additional paper required by law, thirty dollars; (5) for each certificate of valuation, organization, reciprocity or compliance, forty dollars; (6) for each certified copy of a license to a company, forty dollars; (7) for each certified copy of a report or certificate of condition of a company to be filed in any other state, forty dollars; (8) for amending a certificate of authority, two hundred dollars; (9) for each license issued to a rating organization, two hundred dollars. In addition, insurance companies shall pay any fees imposed under section 12-211; (10) a filing fee of fifty dollars for each initial application for a license made pursuant to section 38a-769; (11) with respect to

insurance agents' appointments: (A) A filing fee of fifty dollars for each request for any agent appointment, except that no filing fee shall be payable for a request for agent appointment by an insurance company domiciled in a state or foreign country which does not require any filing fee for a request for agent appointment for a Connecticut insurance company; (B) a fee of one hundred dollars for each appointment issued to an agent of a domestic insurance company or for each appointment continued; and (C) a fee of eighty dollars for each appointment issued to an agent of any other insurance company or for each appointment continued, except that (i) no fee shall be payable for an appointment issued to an agent of an insurance company domiciled in a state or foreign country which does not require any fee for an appointment issued to an agent of a Connecticut insurance company, and (ii) the fee shall be twenty dollars for each appointment issued or continued to an agent of an insurance company domiciled in a state or foreign country with a premium tax rate below Connecticut's premium tax rate; (12) with respect to insurance producers: (A) An examination fee of fifteen dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of fifteen dollars to the commissioner for each examination taken by an applicant; (B) a fee of eighty dollars for each license issued; (C) a fee of eighty dollars per year, or any portion thereof, for each license renewed; and (D) a fee of eighty dollars for any license renewed under the transitional process established in section 38a-784; (13) with respect to public adjusters: (A) An examination fee of fifteen dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of fifteen dollars to the commissioner for each examination taken by an applicant; and (B) a fee of two hundred fifty dollars for each license issued or renewed; (14) with respect to casualty adjusters: (A) An examination fee of twenty dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of twenty dollars to the commissioner for each examination taken by an applicant; (B) a fee of eighty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner two hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (15) with respect to motor vehicle physical damage appraisers: (A) An examination fee of eighty dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of eighty dollars to the commissioner for each examination taken by an applicant; (B) a fee of eighty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner two hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (16) with respect to certified insurance consultants: (A) An examination fee of twenty-six dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of twenty-six dollars to the commissioner for each examination taken by an applicant; (B) a fee of two hundred fifty dollars for each license issued; and (C) a fee of two hundred fifty dollars for each license renewed; (17) with respect to surplus lines brokers: (A) An examination fee of twenty dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of twenty dollars to the commissioner for each examination taken by an applicant; and (B) a fee of six hundred twenty-five dollars for each license issued or renewed; (18) with respect to fraternal agents, a fee of eighty dollars for each license issued or renewed; (19) a fee of twenty-six dollars for each license certificate requested, whether or not a license has been issued; (20) with respect to domestic and foreign benefit societies shall pay: (A) For service of process, fifty dollars for each person or insurer to be served; (B) for filing a certified copy of its charter or articles of association, fifteen dollars; (C) for filing the annual report, twenty

dollars; and (D) for filing any additional paper required by law, fifteen dollars; (21) with respect to foreign benefit societies: (A) For each certificate of organization or compliance, fifteen dollars; (B) for each certified copy of permit, fifteen dollars; and (C) for each copy of a report or certificate of condition of a society to be filed in any other state, fifteen dollars; (22) with respect to reinsurance intermediaries, a fee of six hundred twenty-five dollars for each license issued or renewed; (23) with respect to life settlement providers: (A) A filing fee of twenty-six dollars for each initial application for a license made pursuant to section 38a-465a; and (B) a fee of forty dollars for each license issued or renewed; (24) with respect to life settlement brokers: (A) A filing fee of twenty-six dollars for each initial application for a license made pursuant to section 38a-465a; and (B) a fee of forty dollars for each license issued or renewed; (25) with respect to preferred provider networks, a fee of two thousand seven hundred fifty dollars for each license issued or renewed; (26) with respect to rental companies, as defined in section 38a-799, a fee of eighty dollars for each permit issued or renewed; (27) with respect to medical discount plan organizations licensed under section 38a-479rr, a fee of six hundred twenty-five dollars for each license issued or renewed; (28) with respect to pharmacy benefits managers, an application fee of one hundred dollars for each registration issued or renewed; (29) with respect to captive insurance companies, as defined in section 38a-91aa, a fee of three hundred seventy-five dollars for each license issued or renewed; (30) with respect to each duplicate license issued a fee of fifty dollars for each license issued; (31) with respect to surety bail bond agents, as defined in section 38a-660, (A) a filing fee of one hundred fifty dollars for each initial application for a license, and (B) a fee of one hundred dollars for each license issued or renewed; and (32) with respect to third-party administrators, as defined in section 38a-720, (A) a fee of five hundred dollars for each license issued, (B) a fee of three hundred fifty dollars for each license renewed, and (C) a fee of one hundred dollars for each annual report filed pursuant to section 38a-720/[.]; (33) a filing fee of three thousand dollars for each statement of acquisition of control of a domestic insurance company filed pursuant to section 38a-130; and (34) a filing fee of two thousand dollars for each application for qualified clinical review criteria vendor submitted pursuant to section 38a-591c.

Sec.3. Subsection (e) of section 38a-14 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July1, 2014*):

(e) (1) Nothing contained in this section shall be construed to limit the commissioner's authority to terminate or suspend any examination in order to pursue legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

(2) Nothing contained in this section shall be construed to limit the commissioner's authority in such legal or regulatory action to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of any examination.

(3) Not later than sixty days following completion of the examination, the examiner in charge shall file, under oath, with the Insurance Department a verified written report of examination. Upon receipt of the verified report, the Insurance Department shall transmit the report to the **[**company**]** entity examined, together with a notice **[**which**]** that shall afford the **[**company**]** entity examined a reasonable opportunity, not to exceed thirty days, to make a written submission or

rebuttal with respect to any matters contained in the examination report. Not later than thirty days after the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers and enter an order: (A) Adopting the examination report as filed or with modification or corrections. If the examination report reveals that the **[**company**]** entity is operating in violation of any law, regulation or prior order of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure such violation; (B) rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information, and refiling pursuant to **[**subparagraph (A) of**]** this subdivision; or (C) calling for an investigatory hearing with not less than twenty days' notice to the company for purposes of obtaining additional documentation, data, information and testimony.

(4) (A) The commissioner shall transmit the examination report adopted pursuant to subparagraph (A) of subdivision (3) of this subsection or a summary thereof to the entity examined, together with any recommendations or written statements from the commissioner or the examiner. The secretary of the board of directors or similar governing body of the entity shall provide a copy of the report or summary to each director and shall certify to the commissioner, in writing, that a copy of the report or summary has been provided to each director.

(B) Not later than one hundred twenty days after receiving the report or summary, the chief executive officer or the chief financial officer of the entity examined shall present the report or summary to the entity's board of directors or similar governing body at a regular or special meeting.

Sec. 4. Subsection (e) of section 38a-53 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(e) Any insurance company or health care center doing business in this state **[**which**]** 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 waive the late filing fee if (1) the insurance company or health care center cannot file such report or statement because the Governor of such company's or health care center's state of domicile has proclaimed a state of emergency in such state and such state of emergency impairs the company's or health care center's ability to file the report or statement, or (2) the insurance regulatory official of the state of domicile of a foreign insurance company has permitted the company, or the commissioner has permitted a health care center, to file such report or statement late.

Sec. 5. Subdivision (3) of subsection (e) of section 38a-85 of the general statutes is repealed and the following is substituted in lieu thereof:

(3) (A) (i) In the case of a single assuming insurer, the trust shall consist of a trusteed account with funds in an amount not less than the assuming insurer's liabilities attributable to

reinsurance ceded by domestic and foreign ceding insurers and, unless otherwise provided in subparagraph (A)(ii) of this subdivision, the assuming insurer shall maintain a trusteed surplus of not less than twenty million dollars.

(ii) [For a trust over which the commissioner has principal regulatory oversight, at] At any time after the assuming insurer has permanently discontinued for at least three full years underwriting new business secured by the trust, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus. Such reduction shall be made only after [the] such commissioner finds, based on a risk assessment, that the reduced surplus level is adequate to protect domestic and foreign policyholders and ceding insurers and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including, when applicable, the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required surplus shall not be reduced to an amount less than thirty per cent of the assuming insurer's liabilities attributable to reinsurance ceded by domestic and foreign ceding insurers covered by the trust.

(B) In the case of an assuming insurer that is a group including incorporated and individual unincorporated underwriters:

(i) (I) For reinsurance ceded under a reinsurance agreement with an inception date prior to January 1, 1993, and not amended or renewed after said date, the trust shall consist of a trusteed account with funds in an amount not less than such underwriters' several insurance and reinsurance liabilities attributable to business written in the United States; or

(II) For reinsurance ceded under a reinsurance agreement with an inception date on or after January 1, 1993, the trust shall consist of a trusteed account with funds in an amount not less than such underwriters' several liabilities attributable to business ceded by domestic and foreign ceding insurers to any underwriter who is a member of the group; and

(ii) In addition to a trust specified in subparagraph (B)(i)(I) or (B)(i)(II) of this subdivision, the group shall maintain, for all years of account, a trusteed surplus of which one hundred million dollars shall be held jointly for the benefit of domestic and foreign ceding insurers of any member of the group; and

(iii) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and solvency control by the group's domiciliary insurance regulatory official as are the unincorporated members; and

(iv) Not later than ninety days after its financial statements are due to be filed with the group's domiciliary insurance regulatory official, the group shall provide to the commissioner an annual certification by the group's domiciliary insurance regulatory official of the solvency of each underwriter who is a member of the group or, if such certification is not provided by the group's domiciliary insurance regulatory official, financial statements prepared by independent public accountants of each such underwriter.

(C) In the case of a group of incorporated underwriters under common administration:

(i) The group shall be accredited and have continuously transacted an insurance business outside the United States for at least three years immediately prior to applying for accreditation;

(ii) The trust shall consist of a trusteed account with funds in an amount not less than such underwriters' several liabilities attributable to business ceded by domestic and foreign ceding insurers pursuant to a reinsurance contract issued in the name of the group to any underwriter who is a member of the group;

(iii) In addition to such trust, the group shall maintain (I) an aggregate policyholders' surplus of not less than ten billion dollars, and (II) a joint trusteed surplus of which one hundred million dollars shall be held jointly for the benefit of domestic and foreign ceding insurers of any member of the group as additional security for these liabilities; and

(iv) Not later than ninety days after its financial statements are due to be filed with the group's domiciliary insurance regulatory official, the group shall make available to the commissioner an annual certification by the group's domiciliary insurance regulatory official of the solvency of each underwriter who is a member of the group and financial statements prepared by independent public accountants of each such underwriter.

Sec 6. Subsection (b) of section 38a-136 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(b) (1) The following transactions involving a domestic insurance company and any person in its holding company system, including amendments to or modifications of affiliate agreements previously filed pursuant to this section and that are subject to any materiality standards specified in subparagraphs (A) to (G), inclusive, of this subdivision, may not be entered into unless the insurance company has notified the commissioner in writing of its intention to enter into such transaction at least thirty days prior thereto, or such shorter period as the commissioner may permit, and the commissioner has approved or not disapproved it within such period. The written notice for such amendments or modifications shall specify the reasons for the change and the financial impact on the domestic insurance company. Not later than thirty days after the termination of a previously filed agreement, the domestic insurance company shall notify the commissioner of such termination for the commissioner's determination of what written notice or filing shall be required, if any:

(A) Sales, purchases, exchanges, loans or extensions of credit, or investments, provided such transactions are equal to or exceed: (i) With respect to nonlife insurance companies, the lesser of three per cent of the insurance company's admitted assets or twenty-five per cent of surplus; or (ii) with respect to life insurance companies, three per cent of the insurance company's admitted assets; each as of the thirty-first day of December next preceding;

(B) Loans or extensions of credit to any person who is not an affiliate, where the insurance company makes such loans or extensions of credit with the agreement or understanding that the proceeds of such transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the

insurance company making such loans or extensions of credit, provided such transactions are equal to or exceed: (i) With respect to nonlife insurance companies, the lesser of three per cent of the insurance company's admitted assets or twenty-five per cent of surplus; or (ii) with respect to life insurance companies, three per cent of the insurance company's admitted assets; each as of the thirty-first day of December next preceding;

(C) Reinsurance agreements or modifications thereto, including (i) all reinsurance pooling agreements, and (ii) agreements in which the reinsurance premium or a change in the insurance company's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities in any of the next three years, equals or exceeds five per cent of the insurance company's surplus, as of the thirty-first day of December next preceding, including those agreements that may require as consideration the transfer of assets from an insurance company to a nonaffiliate, if an agreement or understanding exists between the insurance company and nonaffiliate that any portion of such assets will be transferred to one or more affiliates of the insurance company;

(D) All management agreements, service contracts, tax allocation agreements and cost-sharing arrangements;

(E) Guarantees by a domestic insurance company, except that a guarantee that is (i) quantifiable as to amount, and (ii) does not exceed the lesser of one-half of one per cent of the insurance company's admitted assets or ten per cent of surplus with regard to policyholders, as of the thirty-first day of December next preceding, shall not be subject to the notice requirement of this subsection;

(F) Direct or indirect acquisitions or investments in a person that controls the domestic insurance company or in an affiliate of the insurance company in an amount that, together with the insurance company's present holdings in such investments, exceeds two and one-half per cent of the insurance company's surplus with regard to policyholders. This subsection shall not apply to direct or indirect acquisitions of or investments in (i) subsidiaries acquired pursuant to section 38a-102d or authorized pursuant to any section of this title other than sections 38a-129 to 38a-140, inclusive, or (ii) nonsubsidiary affiliates that are subject to the provisions of sections 38a-129 to 38a-140, inclusive; and

(G) Any material transactions, specified by regulation, that the commissioner determines may adversely affect the interests of the insurance company's policyholders.

(2) Nothing contained in this section shall be deemed to authorize or permit any transactions that, in the case of an insurance company not a member of the same insurance holding company system, would be otherwise contrary to law.

Sec. 7. Subsection (b) of section 38a-162 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(b) All licenses issued under the provisions of sections 38a-160 to 38a-170, inclusive, shall expire on the thirtieth day of June following the date of their issuance. At the time of application for an insurance premium finance company license and for every annual renewal thereof there

shall be paid to the commissioner the sum of [fifty] three hundred dollars. If a license is not issued the fee shall be returned.

Sec 8. Subsection (a) of section 38a-163 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) Each applicant for an insurance premium finance company license or for any renewal of such license shall file with the commissioner a written application in such manner and form as the commissioner shall prescribe together with [said fee of fifty dollars which fee shall be returned to the applicant if such license is not granted] the fee specified in subsection (b) of section 38a-162, as amended by this act.

Sec 9. Subsection (a) of section 38a-188 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

Each health care center governed by sections 38a-175 to 38a-192, inclusive, shall be exempt from the provisions of the general statutes relating to insurance in the conduct of its operations under said sections and in such other activities as do constitute the business of insurance, unless expressly included therein, and except for the following: Sections 38a-11, 38a-14a, 38a-17, 38a-51, 38a-52, 38a-56, 38a-57, 38a-129 to 38a-140, inclusive, 38a-147 and 38a-815 to 38a-819, inclusive, provided a health care center shall not be deemed in violation of sections 38a-815 to 38a-819, inclusive, solely by virtue of such center selectively contracting with certain providers in one or more specialties, and sections 38a-80, 38a-492b, 38a-518b, 38a-543, 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to 38a-745, inclusive, as amended by this act, 38a-769, 38a-770, 38a-772 to 38a-776, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794, provided a health care center organized as a nonprofit, nonstock corporation shall be exempt from sections 38a-146, 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to 38a-745, inclusive, as amended by this act, 38a-769, 38a-770, 38a-772 to 38a-776, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794. If a health care center is operated as a line of business, the foregoing provisions shall, where possible, be applied only to that line of business and not to the organization as a whole. The commissioner may adopt regulations, in accordance with chapter 54, stating the circumstances under which the resources of a person which controls a health care center, or operates a health care center as a line of business will be considered in evaluating the financial condition of a health care center. Such regulations, if adopted, shall require as a condition to the consideration of the resources of such person which controls a health care center, or operates a health care center as a line of business to provide satisfactory assurances to the commissioner that such person will assume the financial obligations of the health care center. During the period prior to the effective date of regulations issued under this section, the commissioner shall, upon request, consider the resources of a person which controls a health care center, or operates a health care center as a line of business, if the commissioner receives satisfactory assurances from such person that it will assume the financial obligations of the health care center and determines that such person meets such other requirements as the commissioner determines are necessary. A health care center organized as a nonprofit, nonstock corporation shall be exempt from the sales and use tax and all property of each such corporation shall be exempt from state, district and municipal taxes. Each corporation governed by sections 38a-175 to 38a-192, inclusive, shall be subject to the provisions of sections 38a-903 to 38a-961, inclusive.

Nothing in this section shall be construed to override contractual and delivery system arrangements governing a health care center's provider relationships.

Sec. 10. (NEW) (Effective July 1, 2014)

(a) A domestic surplus lines insurer may issue policies of insurance against any loss from any contingency as provided by the insurance laws of this state, except any coverage which can be placed through a residual market mechanism, as defined in subsection (x) of section 38a-976.

(b) The provisions of section 38a-271 to 38a-278, inclusive, other than section 38a-277, 38a-663 th 38a-691, inclusive, 38a-695 and 38a-836 to 38a-902, inclusive, will not apply to a domestic surplus lines insurer.

Sec 11. Section 38a-702q of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

Except as provided in section 38a-702g and section 38a-702n, sections 38a-702a to 38a-702r, inclusive, shall not apply to [excess and]surplus lines [agents and]brokers licensed pursuant to sections 38a-740 to 38a-745, inclusive, and section 38a-794.

Sec. 12. Subsection (a) of section 38a-712 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) Each insurance company authorized or permitted to do business in this state and each residual market mechanism established pursuant to section 38a-329 shall report to the Insurance Commissioner (1) any failure on the part of an insurance producer or [excess line] surplus lines broker to remit premiums for policies or endorsements issued to insureds directly or through the producer within thirty days following the due date of the account of the producer with the company, its state agent or managing general agent or (2) whenever a check issued by such producer to the company or residual market mechanism is returned for insufficient funds or otherwise dishonored and remains outstanding fifteen days following receipt of such return.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID1101AffordableCareActConformingChanges

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Insurance Department

Liaison: Jim Perras
Phone: 860 -297-3864
E-mail: jim.perras@ct.gov

Lead agency division requesting this proposal:
Life and Health

Agency Analyst/Drafter of Proposal:
Mary Ellen Breault, Tim Lyons

Title of Proposal
An Act Concerning Changes in State Insurance Law to conform to the Affordable Care Act

Statutory Reference
Sections 38a-183, 38a-476, 38a-478g, 38a-481, 38a-512a, 38a-513,38a-538, 38a-546, 38a-551 through 38a-556, 38a-564 through 38a-574

Proposal Summary

Section 1. This proposed change requires health care centers to meet the Affordable Care Act requirements for individual and group rates.

Section 2. This proposed change prohibits the use of a pre-existing conditions provision in individual or group plans under the Affordable Care Act.

Section 3. This proposed change eliminates the requirement of a coverage privilege, now that the Affordable Care Act provides for guaranteed issue coverage with no pre-existing conditions limitation.

Section 4. This proposed change will make Connecticut's insurance law concerning individual health insurance rates consistent with the federal requirements.

Sections 5. As with section 3 above, these proposed changes eliminate the requirement of a conversion privilege.

Section 6. This proposed change would give the Insurance Department authority to approve small group rates for indemnity products. Currently the Department has authority over all individual rates but only for group rates for HMO products. This change will support the Department's role as providing an effective rate review process under the Affordable Care Act.

Section 7. This change again eliminates the conversion requirement.

Section 8. The HRA plans are no longer needed now that individuals and small employers can get

guaranteed issue coverage with no pre-existing conditions limitations under the Affordable Care Act. Section 38a-538 is no longer needed, in view of the Affordable Care Act protections.

Section 9. The Affordable Care Act has requirements concerning deductibles, coinsurance and waiting periods, so Connecticut's rules in section 38a-546 are no longer needed.

Sections 10 through 15.These changes all relate to the Health Reinsurance Association which has been offering a health insurance plan of last resort for persons with medical conditions who couldn't obtain coverage elsewhere. These HRA individual and group comprehensive plans are no longer needed due to the Affordable Care Act's guaranteed issue requirements and prohibition on pre-existing conditions. The Association is still left in place, however, in case any need for unusual health programs not in the market arises in the future.

Sections 16 through 25.These changes all relate to Connecticut's existing small group laws.

Section 16 amends the Connecticut definitions to be consistent with the federal requirements and to eliminate definitions related to former HRA programs (which are being eliminated under sections 10 through 15).

Section 17 repeals section 38a-565 as the type of special health care plan described in section 38a-565 is no longer needed, in view of the new health insurance marketplace beginning operations in Connecticut on October 1, 2013, which marketplace may provide federal premium subsidies for qualifying individuals.

Section 18 amends section 38a-566 as the Affordable Care Act has different requirements for sole proprietors.

Section 19 amends section 38a-567 to make it consistent with the rating requirements for small group plans under the Affordable Care Act.

Section 20 repeals section 38a-568 as the Affordable Care Act has new and different requirements related to plan design and Essential Health Benefits.

Section 21 amends section 38a-569 related to the Connecticut Small Employer Health Insurance Pool and deletes obsolete subsections.

Sections 22, 23 and 24 repeal sections 38a-570, 38a-571, and 38a-572 as the special health plans are no longer needed in view of the new health insurance marketplaces under the Affordable Care Act.

Section 25 amends section 38a-574 as medical underwriting is not permitted under the Affordable Care Act.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? Yes, many of the relevant Affordable Care Act provisions take effect January 1, 2014

(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?

(3) Have certain constituencies called for this action? Major health insurance companies active in HRA and CSERHP leadership have called for many of these changes.

(4) What would happen if this was not enacted in law this session? Federal law prevails but the Insurance Department believes it is prudent to have Connecticut insurance law clear and consistent with the Affordable Care Act.

- **Origin of Proposal** **__X_ New Proposal** **___ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: N/A
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) N/A
State N/A
Federal N/A
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Section 1. Section 38a-183 of the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

Sec. 38a-183. (a) A health care center governed by sections 38a-175 to 38a-192, inclusive, shall not enter into any agreement with subscribers unless and until it has filed with the commissioner a full schedule of the amounts to be paid by the subscribers and has obtained the commissioner's approval thereof. The commissioner may refuse such approval if he finds such amounts to be excessive, inadequate or discriminatory. Each such health care center shall not enter into any agreement with subscribers unless and until it has filed with the commissioner a copy of such agreement or agreements, including all riders and endorsements thereon, and until the commissioner's approval thereof has been obtained. The commissioner shall, within a reasonable time after the filing of any request for an approval of the amounts to be paid, any agreement or any form, notify the health care center of either his approval or disapproval thereof.

(b) (1) A health care center may establish rates of payment by any method permitted by the Federal Health Maintenance Organization Act and the regulations adopted thereunder from time to time unless otherwise determined by the commissioner by regulation. Rate filings shall include an actuarial memorandum that includes, but is not limited to, pricing assumptions and claims experience, premium rates and loss ratios from the inception of the policy.

(2) Rates offered to individuals shall be consistent with the requirements set forth in section 38a-481.

(3) Rates offered to small employer groups shall be consistent with the requirements set forth in section 38a-567.

(c) Each such health care center may include as a component of its rate a sum up to ten per cent of such rate to be used for the objects and purposes set forth in section 38a-184. An amount not exceeding ten per cent of the annual net premium income of such center may be set aside annually as a capital reserve fund and may be accumulated from year to year by such health care center, to be expended for the objects and purposes as set forth and in accordance with said section.

Section 2. Section 38a-476 of the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

Sec. 38a-476. Preexisting condition coverage. (a)(1) For the purposes of this section, "health insurance plan" means any hospital and medical expense incurred policy, hospital or medical service plan contract and health care center subscriber contract and does not include (A) short-term health insurance issued on a nonrenewable basis with a duration of six months or less, 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 that the carrier offering such policies files on or before March first of each year a certification with the Insurance 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.

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

(3) "Preexisting conditions provision" means a policy provision which limits or excludes benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, for which any medical advice, diagnosis, care or treatment was recommended or received before such effective date. Routine follow-up care to determine whether a breast cancer has reoccurred in a person who has been previously determined to be breast cancer free shall not be considered as medical advice, diagnosis, care or treatment for purposes of this section unless evidence of breast cancer is found during or as a result of such follow-up. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to such information. Pregnancy shall not be considered a preexisting condition.

[(4) "Qualifying coverage" means (A) any group health insurance plan, insurance arrangement or self-insured plan, (B) Medicare or Medicaid, or (C) an individual health insurance plan that provides benefits which are actuarially equivalent to or exceeding the benefits provided under the small employer health care plan, as defined in subdivision (12) of section 38a-564, whether issued in this state or any other state.]

[(5)] (4) "Applicable waiting period" means the period of time imposed by the group policyholder or contractholder before an individual is eligible for participating in the group policy or contract.

(b) (1) No group health insurance plan or insurance arrangement shall impose a preexisting conditions provision [that excludes coverage for (A) individuals eighteen years of age and younger, or (B) a period beyond twelve months following the insured's effective date of coverage. Any preexisting conditions provision shall only relate to conditions, whether physical or mental, for which medical advice, diagnosis or care or treatment was recommended or received during the six months immediately preceding the effective date of coverage] on any individual.

(2) No individual health insurance plan or insurance arrangement shall impose a preexisting conditions provision [that excludes coverage for (A) individuals eighteen years of age and younger, or (B) a period beyond twelve months following the insured's effective date of coverage. Any preexisting conditions provision shall only relate to conditions, whether physical or mental, for which medical advice, diagnosis or care or treatment was recommended or received during the twelve months immediately preceding the effective date of coverage] on any individual.

(3) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center shall refuse to issue an individual health insurance plan or insurance arrangement to [individuals eighteen years of age and younger] any individual solely on the basis that an individual has a preexisting condition.

[(c) All health insurance plans and insurance arrangements shall provide coverage, under the terms and conditions of their policies or contracts, for the preexisting conditions of any newly insured individual who was previously covered for such preexisting condition under the terms of the individual's preceding qualifying coverage, provided the preceding coverage was continuous to a date less than one hundred twenty days prior to the effective date of the new coverage, exclusive of any applicable waiting period, except in the case of a newly insured group member whose previous coverage was terminated due to an involuntary loss of employment, the preceding coverage must have been continuous to a date not more than one hundred fifty days prior to the effective date of the new coverage, exclusive of any applicable waiting period, provided such newly insured group member or dependent applies for such succeeding coverage within thirty days of the member's or dependent's initial eligibility.

(d) With respect to a newly insured individual who was previously covered under qualifying coverage, but who was not covered under such qualifying coverage for a

preexisting condition, as defined under the new health insurance plan or arrangement, such plan or arrangement shall credit the time such individual was previously covered by qualifying coverage to the exclusion period of the preexisting condition provision, provided the preceding coverage was continuous to a date less than one hundred twenty days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan, except in the case of a newly insured group member whose preceding coverage was terminated due to an involuntary loss of employment, the preceding coverage must have been continuous to a date not more than one hundred fifty days prior to the effective date of the new coverage, exclusive of any applicable waiting period, provided such newly insured group member or dependent applies for such succeeding coverage within thirty days of the member's or dependent's initial eligibility.

(e) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center which issues in this state group health insurance subject to Section 2701 of the Public Health Service Act, as set forth in the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (HIPAA), as amended from time to time, shall comply with the provisions of said section with respect to such group health insurance, except that the longer period of days specified in subsections (c) and (d) of this section shall apply to the extent excepted from preemption in Section 2723(B)(2)(iii) of said Public Health Service Act.

(f) The provisions of this section shall apply to every health insurance plan or insurance arrangement issued, renewed or continued in this state on or after October 1, 1993. For purposes of this section, the date a plan or arrangement is continued shall be the anniversary date of the issuance of the plan or arrangement. The provisions of subsection (e) of this section shall apply on and after the dates specified in Sections 2747 and 2792 of the Public Health Service Act as set forth in HIPAA.]

[(g)] (c) Notwithstanding the provisions of subsection (a) of this section, a short-term health insurance policy issued on a nonrenewable basis for six months or less which imposes a preexisting conditions provision shall be subject to the following conditions: (1) No such preexisting conditions provision shall exclude coverage beyond twelve months following the insured's effective date of coverage; (2) such preexisting conditions provision may only relate to conditions, whether physical or mental, for which medical advice, diagnosis, care or treatment was recommended or

received during the twenty-four months immediately preceding the effective date of coverage; and (3) any policy, application or sales brochure issued for such short-term health insurance policy that imposes such preexisting conditions provision shall disclose in a conspicuous manner in not less than fourteen-point bold face type the following statement:

"THIS POLICY EXCLUDES COVERAGE FOR CONDITIONS FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED DURING THE TWENTY-FOUR MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF COVERAGE."

In the event an insurer or health care center issues two consecutive short-term health insurance policies on a nonrenewable basis for six months or less which imposes a preexisting conditions provision to the same individual, the insurer or health care center shall reduce the preexisting conditions exclusion period in the second policy by the period of time such individual was covered under the first policy. If the same insurer or health care center issues a third or subsequent such short-term health insurance policy to the same individual, such insurer or health care center shall reduce the preexisting conditions exclusion period in the third or subsequent policy by the cumulative time covered under the prior policies. Nothing in this section shall be construed to require such short-term health insurance policy to be issued on a guaranteed issue or guaranteed renewable basis.

[(h) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to enforce the provisions of HIPAA and this section concerning preexisting conditions and portability.]

Section 3. Section 38a-478g of the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

(a) Each managed care contract delivered, issued for delivery, renewed, amended or continued in this state shall be in writing and a copy thereof furnished to the group contract holder or individual contract holder, as appropriate. Each such contract shall contain the following provisions: (1) Name and address of the managed care organization; (2) eligibility requirements; (3) a statement of copayments, deductibles or other out-of-pocket expenses the enrollee must pay; (4) a statement of the nature

of the health care services, benefits or coverages to be furnished and the period during which they will be furnished and, if there are any services, benefits or coverages to be excepted, a detailed statement of such exceptions; (5) a statement of terms and conditions upon which the contract may be cancelled or otherwise terminated at the option of either party; (6) claims procedures; (7) enrollee grievance procedures; (8) continuation of coverage; [(9) conversion;] [(10)] (9) extension of benefits, if any; [(11)] (10) subrogation, if any; [(12)] (11) description of the service area, and out-of-area benefits and services, if any; [(13)] (12) a statement of the amount the enrollee or others on his behalf must pay to the managed care organization and the manner in which such amount is payable; [(14)] (13) a statement that the contract includes the endorsement thereon and attached papers, if any, and contains the entire contract; [(15)] (14) a statement that no statement by the enrollee in his application for a contract shall void the contract or be used in any legal proceeding thereunder, unless such application or an exact copy thereof is included in or attached to such contract; and [(16)] (15) a statement of the grace period for making any payment due under the contract, which shall not be less than ten days. The commissioner may waive the requirements of this subsection for any managed care organization subject to the provisions of section 38a-182.

(b) Each managed care organization shall provide every enrollee with a plan description. The plan description shall be in plain language as commonly used by the enrollees and consistent with chapter 699a. The plan description shall be made available to each enrollee and potential enrollee prior to the enrollee's entering into the contract and during any open enrollment period. The plan description shall not contain provisions or statements that are inconsistent with the plan's medical protocols. The plan description shall contain:

(1) A clear summary of the provisions set forth in subdivisions (1) to (12), inclusive, of subsection (a) of this section, subdivision (3) of subsection (a) of section 38a-478c and sections 38a-478j to 38a-478*l*, inclusive;

(2) A statement of the number of managed care organization's utilization review determinations not to certify an admission, service, procedure or extension of stay, and the denials upheld and reversed on appeal within the managed care organization's utilization review procedure;

(3) A description of emergency services, the appropriate use of emergency services, including the use of E 9-1-1 telephone systems, any cost sharing applicable to emergency services and the location of emergency departments and other settings in

which participating physicians and hospitals provide emergency services and post stabilization care;

(4) Coverage of the plans, including exclusions of specific conditions, ailments or disorders;

(5) The use of drug formularies or any limits on the availability of prescription drugs and the procedure for obtaining information on the availability of specific drugs covered;

(6) The number, types and specialties and geographic distribution of direct health care providers;

(7) Participating and nonparticipating provider reimbursement procedure;

(8) Preauthorization and utilization review requirements and procedures, internal grievance procedures and internal and external complaint procedures;

(9) The state medical loss ratio and the federal medical loss ratio, as both terms are defined in section 38a-478*l*, as reported in the last Consumer Report Card on Health Insurance Carriers in Connecticut;

(10) The plan's for-profit, nonprofit incorporation and ownership status;

(11) Telephone numbers for obtaining further information, including the procedure for enrollees to contact the organization concerning coverage and benefits, claims grievance and complaint procedures after normal business hours;

(12) How notification is provided to an enrollee when the plan is no longer contracting with an enrollee's primary care provider;

(13) The procedures for obtaining referrals to specialists or for consulting a physician other than the primary care physician;

(14) The status of the National Committee for Quality Assurance (NCQA) accreditation;

(15) Enrollee satisfaction information; and

(16) Procedures for protecting the confidentially of medical records and other patient information.

Section 4. Section 38a-481 of the general statutes as amended by Public Act 13-149 is repealed and the following is substituted in lieu thereof (Effective from passage):

(a) (1) No individual health insurance policy shall be delivered or issued for delivery to any person in this state, nor shall any application, rider or endorsement be used in connection with such policy, until a copy of the form thereof and of the classification of risks and the premium rates have been filed with the commissioner. [Rate filings shall include an actuarial memorandum that includes, but is not limited to, pricing assumptions and claims experience, premium rates and loss ratios from the inception of the policy.] The commissioner [shall] may adopt regulations, in accordance with chapter 54, to establish a procedure for reviewing such policies. The commissioner shall disapprove the use of such form at any time if it does not comply with the requirements of law, or if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy. The commissioner shall notify, in writing, the insurer which has filed any such form of the commissioner's disapproval, specifying the reasons for disapproval, and ordering that no such insurer shall deliver or issue for delivery to any person in this state a policy on or containing such form. The provisions of section 38a-19 shall apply to such orders.

(2) Any such policy shall be offered on a guaranteed issue basis with respect to all eligible individuals or dependents.

(b) (1) No rate filed under the provisions of subsection (a) of this section shall be effective until it has been filed and approved by the commissioner in accordance with regulations adopted pursuant to this subsection. The commissioner [shall] may adopt regulations, in accordance with chapter 54, to prescribe standards to ensure that such rates shall not be excessive, inadequate or unfairly discriminatory. The commissioner may disapprove such rate [within thirty days after it has been filed] if it fails to comply with such standards, except that no rate filed under the provisions of subsection (a) of this section for any Medicare supplement policy shall be effective unless approved in accordance with section 38a-474.

(2) Rate filings shall include an actuarial memorandum that includes, but is not limited to, pricing assumptions and claims experience, premium rates and loss ratios from the inception of the policy.

(3) With respect to grandfathered policies issued to individuals, the premium rates charged or offered shall be established on the basis of a single pool of all grandfathered plans, adjusted to reflect one or more of the following classifications:

(i) Age in accordance with a uniform age rating curve established by the commissioner; and

(ii) Geographic area as defined by the commissioner; and

(iii) Tobacco use, except that such rate may not vary by more than 1.5 to 1 and may only be applied with respect to individuals who may legally use tobacco under federal and state law. For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco.

(4) With respect to non-grandfathered policies issued to individuals, the premium rates charged or offered shall be established on the basis of a single pool of all non-grandfathered plans, adjusted to reflect one or more of the following classifications:

(i) Age in accordance with a uniform age rating curve established by the commissioner; and

(ii) Geographic area as defined by the commissioner; and

(iii) Tobacco use, except that such rate may not vary by more than 1.5 to 1 and may only be applied with respect to individuals who may legally use tobacco under federal and state law. For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco.

(5) Grandfathered and non-grandfathered policies have the meaning as defined in the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and regulations adopted thereunder.

(6) The premium rate for any given plan may vary by actuarially justified differences in plan design.

(7) The total premium for family coverage must be determined by summing the premiums for each individual family member. With respect to family members under the age of 21, the premiums for no more than the three oldest covered children must be taken into account in determining the total family premium.

(8) The premium rate for any given plan may vary by actuarially justified amounts to reflect the plan's provider network and administrative expense differences that can be reasonably allocated to that plan.

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

(d) For the purposes of this section:

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

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

(e) Nothing in this chapter shall preclude the issuance of an individual health insurance policy that includes an optional life insurance rider, provided the optional life insurance rider shall be filed with and approved by the Insurance Commissioner pursuant to section 38a-430. Any company offering such policies for sale in this state shall be licensed to sell life insurance in this state pursuant to the provisions of section 38a-41.

(f) [No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity that delivers, issues for delivery, amends, renews or continues an individual health insurance policy in this state shall: (1) Move an insured individual from a standard underwriting classification to a substandard underwriting classification after the policy is issued; (2) increase premium rates due to the claim experience or health status of an

individual who is insured under the policy, except that the entity may increase premium rates for all individuals in an underwriting classification due to the claim experience or health status of the underwriting classification as a whole; or (3) use an individual's history of taking a prescription drug for anxiety for six months or less as a factor in its underwriting unless such history arises directly from a medical diagnosis of an underlying condition.] Health insurance issued to an association or other insurance arrangement that is not made up solely of employer groups shall be treated as individual health insurance.

Section 5. Section 38a-512a of the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

(a)(1) Each insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity delivering, issuing for delivery, renewing, amending or continuing a group health insurance policy in this state that provides coverage of the type specified in subdivisions (1), (2), (3), (4), (11) and (12) of section 38a-469 shall provide the option to continue coverage under each of the following circumstances until the individual is eligible for other group insurance, except as provided in subparagraphs (C) and (D) of this subdivision:

(A) Upon layoff, reduction of hours, leave of absence or termination of employment, other than as a result of death of the employee or as a result of such employee's "gross misconduct" as that term is used in 29 USC 1163(2), continuation of coverage for such employee and such employee's covered dependents for a period of thirty months after the date of such layoff, reduction of hours, leave of absence or termination of employment, except that if such reduction of hours, leave of absence or termination of employment results from an employee's eligibility to receive Social Security income, continuation of coverage for such employee and such employee's covered dependents until midnight of the day preceding such person's eligibility for benefits under Title XVIII of the Social Security Act;

(B) Upon the death of the employee, continuation of coverage for the covered dependents of such employee for the periods set forth for such event under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended from time to time;

(C) Regardless of the employee's or dependent's eligibility for other group insurance, during an employee's absence due to illness or injury, continuation of coverage for

such employee and such employee's covered dependents during continuance of such illness or injury or for up to twelve months from the beginning of such absence;

(D) Regardless of an individual's eligibility for other group insurance, upon termination of the group policy, coverage for covered individuals who were totally disabled on the date of termination shall be continued without premium payment during the continuance of such disability for a period of twelve calendar months following the calendar month in which such policy was terminated, provided claim is submitted for coverage within one year of the termination of such policy;

(E) The coverage of any covered individual shall terminate: (i) As to a child, (I) as set forth in section 38a-512b. If on the date specified for termination of coverage on a child, the child is incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the employee for support and maintenance, the coverage on such child shall continue while the plan remains in force and the child remains in such condition, provided proof of such handicap is received by such insurer, center, corporation, society or other entity within thirty-one days of the date on which the child's coverage would have terminated in the absence of such incapacity. Such insurer, center, corporation, society or other entity may require subsequent proof of the child's continued incapacity and dependency but not more often than once a year thereafter, or (II) for the periods set forth for such child under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended from time to time; (ii) as to the employee's spouse, at the end of the month following the month in which a divorce, court-ordered annulment or legal separation is obtained, whichever is earlier, except that the plan shall provide the option for said spouse to continue coverage for the periods set forth for such events under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended from time to time; and (iii) as to the employee or dependent who is sixty-five years of age or older, as of midnight of the day preceding such person's eligibility for benefits under Title XVIII of the federal Social Security Act;

(F) As to any other event listed as a "qualifying event" in 29 USC 1163, as amended from time to time, continuation of coverage for such periods set forth for such event in 29 USC 1162, as amended from time to time, provided such plan may require the individual whose coverage is to be continued to pay up to the percentage of the

applicable premium as specified for such event in 29 USC 1162, as amended from time to time.

(2) Any continuation of coverage required by this subsection except subparagraph (D) or (F) of subdivision (1) of this subsection may be subject to the requirement, on the part of the individual whose coverage is to be continued, that such individual contribute that portion of the premium the individual would have been required to contribute had the employee remained an active covered employee, except that the individual may be required to pay up to one hundred two per cent of the entire premium at the group rate if coverage is continued in accordance with subparagraph (A), (B) or (E) of subdivision (1) of this subsection. The employer shall not be legally obligated by section 38a-505 or 38a-546 to pay such premium if not paid timely by the employee.

[(b) The plan shall make available to Connecticut residents, in addition to any other conversion privilege available, a conversion privilege under which coverage shall be available immediately upon termination of coverage under the group policy. The terms and benefits offered under the conversion benefits shall be at least equal to the terms and benefits of an individual health insurance policy.]

[(c)] (b) Nothing in this section shall alter or impair existing group policies which have been established pursuant to an agreement which resulted from collective bargaining, and the provisions required by this section shall become effective upon the next regular renewal and completion of such collective bargaining agreement.

Section 6. Section 38a-513 of the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

(a) No group health insurance policy, as defined by the commissioner, or certificate shall be issued or delivered in this state unless a copy of the form for such policy or certificate has been submitted to and approved by the commissioner under the regulations adopted pursuant to this section. The commissioner shall adopt regulations, in accordance with chapter 54, concerning the provisions, submission and approval of such policies and certificates and establishing a procedure for reviewing such policies and certificates. If the commissioner issues an order

disapproving the use of such form, the provisions of section 38a-19 shall apply to such order.

(b)(1) No small group health insurance policy or certificate shall be issued or delivered in this state unless the premium rates have been submitted to and approved by the commissioner. Rate filings shall include an actuarial memorandum that includes, but is not limited to, pricing assumptions and claims experience, premium rates and loss ratios from the inception of the policy.

[(b)] (2) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity which delivers or issues for delivery in this state any Medicare supplement policies or certificates shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age, gender, previous claims history or the medical condition of any person covered by such policy or certificate.

(c) Nothing in this chapter shall preclude the issuance of a group health insurance policy which includes an optional life insurance rider, provided the optional life insurance rider must be filed with and approved by the Insurance Commissioner pursuant to section 38a-430. Any company offering such policies for sale in this state shall be licensed to sell life insurance in this state pursuant to the provisions of section 38a-41.

(d) Not later than January 1, 2009, the commissioner shall adopt regulations, in accordance with chapter 54, to establish minimum standards for benefits in group specified disease policies, certificates, riders, endorsements and benefits.

Section 7. Section 38a-537 of the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

(a) Any individual, partnership, corporation, or unincorporated association providing group health insurance coverage for its employees shall furnish each insured employee, upon cancellation or discontinuation of such health insurance, notice of the cancellation or discontinuation of such insurance. The notice shall be mailed or delivered to the insured employee not less than fifteen days next preceding the effective date of cancellation or discontinuation. Any individual or any such entity that fails to provide timely notice shall be fined not more than two thousand dollars

for each violation. The Labor Commissioner shall have the authority to assess all such fines. This section shall apply to any such individual, partnership, corporation or unincorporated association that substitutes one policy providing group health insurance coverage for another such policy with no interruption in coverage.

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

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

[(d) Whenever an employer ceases doing business, any terminated employee whose group health insurance was discontinued on or before the date of termination of employment and who did not receive notice of such discontinuation pursuant to subsection (a) of this section shall be eligible for ninety days from the date of discontinuation to purchase as a conversion privilege an individual comprehensive health care plan for himself and any dependents covered by the discontinued group health insurance plan from the former insurer, hospital or medical service corporation, health care center or the Health Reinsurance Association, if any insurer is not issuing such coverage, with coverage retroactive to the date of discontinuation. The employee shall pay the premiums for the period of retroactive coverage. No retroactive coverage may be purchased for a period during which the employee is eligible for benefits under another group plan.]

Section 8. Section 38a-538 of the general statutes is repealed (Effective from passage):

[Each employer shall allow individuals to elect to continue coverage under a group plan pursuant to section 38a-554.]

Section 9. Section 38a-546 of the general statutes is repealed (Effective from passage):

[(a) In any case of the discontinuance of a group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (3), (4), (11) and (12) of section 38a-469 and delivered, issued for delivery, renewed, amended or continued in this state and the subsequent replacement of such coverage with another such policy, the succeeding carrier, in applying any deductible, coinsurance or waiting period provisions in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible or coinsurance provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible or coinsurance provisions of the prior carrier's plan during the ninety days preceding the effective date of the succeeding carrier's plan but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to a similar deductible or coinsurance provision.

(b) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, covering group coverage discontinuance and replacement.

(c) Nothing in this section shall alter or impair existing group policies which have been established pursuant to an agreement which resulted from collective bargaining, and the provisions required by this section shall become effective upon the next regular renewal and completion of such collective bargaining agreement.]

Section 10. Section 38a-551 of the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

PART IV
[COMPREHENSIVE HEALTH CARE PLANS] HEALTH REINSURANCE ASSOCIATION

For the purposes of this section and sections 38a-552 to 38a-559, inclusive, the following terms shall have the following meanings:

(a) "Health insurance" means hospital and medical expenses incurred policies written on a direct basis, nonprofit service plan contracts, health care center contracts and self-insured or self-funded employee health benefit plans. For purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, "health insurance" does not include (1) 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 (2) policies of specified disease or limited benefit health insurance, provided: (A) 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; and (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 policy in the state; and (B) for each such policy that is offered for the first time in this state on or after July 1, 2005, the carrier files with the commissioner the information and statement required in subparagraph (A) of this subdivision at least thirty days prior to the date such policy is issued or delivered in this state.

(b) "Carrier" means an insurer, health care center, hospital service corporation or medical service corporation or fraternal benefit society.

(c) "Insurer" means an insurance company licensed to transact accident and health insurance business in this state.

(d) "Health care center" means a health care center, as defined in section 38a-175.

(e) "Self-insurer" means an employer or an employee welfare benefit fund or plan which provides payment for or reimbursement of the whole or any part of the cost of covered hospital or medical expenses for covered individuals. For purposes of sections 38a-505[, 38a-546] and 38a-551 to 38a-559, inclusive, "self-insurer" shall not include any such employee welfare benefit fund or plan established prior to April 1, 1976, by any organization which is exempt from federal income taxes under the provisions of Section 501 of the United States Internal Revenue Code and amendments thereto and legal interpretations thereof, except any such organization described in Subsection (c)(15) of said Section 501.

(f) "Commissioner" means the Insurance Commissioner of the state of Connecticut.

(g) "Physician" means a doctor of medicine, chiropractic, natureopathy, podiatry, a qualified psychologist and, for purposes of oral surgery only, a doctor of dental surgery or a doctor of medical dentistry and, subject to the provisions of section 20-138d, optometrists duly licensed under the provisions of chapter 380.

(h) "Qualified psychologist" means a person who is duly licensed or certified as a clinical psychologist and has a doctoral degree in and at least two years of supervised experience in clinical psychology in a licensed hospital or mental health center.

(i) "Skilled nursing facility" shall have the same meaning as "skilled nursing facility", as defined in Section 1395x, Chapter 7 of Title 42, United States Code.

(j) "Hospital" shall have the same meaning as "hospital", as defined in Section 1395x, Chapter 7 of Title 42, United States Code.

(k) "Home health agency" shall have the same meaning as "home health agency", as defined in Section 1395x, Chapter 7 of Title 42, United States Code.

(l) "Copayment" means the portion of a charge that is covered by a plan and not payable by the plan and which is thus the obligation of the covered individual to pay.

(m) "Resident employer" means any person, partnership, association, trust, estate, limited liability company, corporation, whether foreign or domestic, or the legal representative, trustee in bankruptcy or receiver or trustee, thereof, or the legal representative of a deceased person, including the state of Connecticut and each municipality therein, which has in its employ one or more individuals during any calendar year, commencing January 1, 1976. For purposes of sections 38a-505[, 38a-

546] and 38a-551 to 38a-559, inclusive, the term "resident employer" shall refer only to an employer with a majority of employees employed within the state of Connecticut.

(n) "Eligible employee" means, with respect to any employer, an employee who either is considered a full-time employee, or who is expected to work at least twenty hours a week for at least twenty-six weeks during the next twelve months or who has actually worked at least twenty hours a week for at least twenty-six weeks in any continuous twelve-month period.

(o) "Alcoholism treatment facility" shall have the same meaning as in section 38a-533.

(p) "Totally disabled" means with respect to an employee, the inability of the employee because of an injury or disease to perform the duties of any occupation for which he is suited by reason of education, training or experience, and, with respect to a dependent, the inability of the dependent because of an injury or disease to engage in substantially all of the normal activities of persons of like age and sex in good health.

(q) "Deductible" means the amount of covered expenses which must be accumulated during each calendar year before benefits become payable as additional covered expenses incurred.

(r) For purposes of sections 38a-505[, 38a-546] and 38a-551 to 38a-559, inclusive, "disease or injury" shall include pregnancy and resulting childbirth or miscarriage.

(s) "Complications of pregnancy" means (1) conditions requiring hospital stays, when the pregnancy is not terminated, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, and shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and (2) nonelective caesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

(t) "Resident" means (1) a person who maintains a residence in this state for a period of at least one hundred eighty days, or (2) a[HIPAA or] health care tax credit eligible individual who maintains a residence in this state.

[(u) "HIPAA eligible individual" means an eligible individual as defined in subsection (b) of section 2741 of the Public Health Service Act, as set forth in the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (HIPAA).]

[(v)] (u) "Health care tax credit eligible individual" means a person who is eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986 in accordance with the Pension Benefit Guaranty Corporation and Trade Adjustment Assistance programs of the Trade Act of 2002 (P.L. 107-210).

Section 11. Section 38a-552 of the general statutes is repealed (Effective from passage):

[(a)(1) Every carrier offering individual health insurance in this state shall, as a condition of transacting such health insurance, make an individual comprehensive health care plan, described in section 38a-555, available to every resident of this state except residents who are both sixty-five years of age or older and eligible for Medicare. Individual comprehensive health care plans may be made available through participation in the Health Reinsurance Association in accordance with section 38a-556, or a residual market association, in accordance with section 38a-557. The premium charged for such a plan which is not insured by or through the Health Reinsurance Association or any other residual market association may not exceed the premium which would be applicable through participation in such associations. The premium charged for such a plan insured by or through the Health Reinsurance Association shall be precisely the premium established for that particular classification under the Health Reinsurance Association. (2) Every self-insurer whose plan covers three or more employees shall make an individual comprehensive health care plan, described in section 38a-555, available under a conversion privilege to every person covered by the plan who is a resident of this state, who is not eligible for Medicare and whose coverage under the self-insured plan ceases as a result of layoff, death or termination of employment. The individual comprehensive health care plans may be provided through a carrier or through participation in the Health Reinsurance Association in accordance with section 38a-

556. The premium charged for such a plan which is not insured by or through the Health Reinsurance Association may not exceed the premium established for that particular classification under the Health Reinsurance Association. The premium charged for such a plan which is insured by or through the Health Reinsurance Association shall be precisely the premium established for that particular classification under the Health Reinsurance Association.

(b) Every carrier offering group health insurance in this state shall, as a condition of transacting such health insurance, make a group comprehensive health care plan, as described in section 38a-554, available to every resident employer who is not a small employer as defined in subdivision (4) of section 38a-564.

(c) Except as provided in subdivision (c) of section 38a-505, nothing in sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, shall preclude the right of carriers to transact other kinds of insurance for which they are authorized, nor preclude the right of carriers to transact any other lawful kind of health insurance.

(d) Nothing in sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, shall require a carrier to make available coverage under a group or individual comprehensive health care plan to any person or group who is already covered under such a plan.]

Section 12. Section 38a-553 of the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

[All individual and all group comprehensive health care plans shall include minimum standard benefits as described in this section.

(a) Except as provided in subsections (b) and (c), minimum standard benefits shall be benefits, including coverage for catastrophic illness, with a lifetime maximum of one million dollars per individual, for reasonable charges or, when applicable, the allowance agreed upon between a provider and a carrier for charges actually incurred, for the following health care services, rendered to an individual covered by such plan for the diagnosis or treatment of nonoccupational disease or injury: (1) Hospital services; (2) professional services which are rendered by a physician or, at his direction, by a registered nurse, other than services for mental or dental

conditions; (3) the diagnosis or treatment of mental conditions, in accordance with the minimum requirements established in section 38a-514; (4) legend drugs requiring a prescription of a physician, advanced practice registered nurse or physician assistant; (5) services of a skilled nursing facility for not more than one hundred twenty days in a calendar year, provided such services commence within fourteen days following a confinement of at least three consecutive days in a hospital for the same condition; (6) home health agency services, as defined by the commissioner, up to a maximum of one hundred eighty visits in a calendar year, provided such services commence within seven days following confinement in a hospital or skilled nursing facility of at least three consecutive days for the same condition, provided further, in the case of an individual diagnosed by a physician as terminally ill with a prognosis of six months or less to live, such home health agency services may commence irrespective of whether such covered person was so confined or, if such covered person was so confined, irrespective of such seven-day period, and the yearly benefit for medical social services, as hereinafter defined, shall not exceed two hundred dollars. "Medical social services" means services rendered, under the direction of a physician by a qualified social worker holding a master's degree from an accredited school of social work, including but not limited to (A) assessment of the social, psychological and family problems related to or arising out of such covered person's illness and treatment; (B) appropriate action and utilization of community resources to assist in resolving such problems; (C) participation in the development of treatment for such covered person; (7) use of radium or other radioactive materials; (8) outpatient chemotherapy for the removal of tumors and treatment of leukemia, including outpatient chemotherapy; (9) oxygen; (10) anesthetics; (11) nondental prosthesis and maxillo-facial prosthesis used to replace any anatomic structure lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis; (12) rental of durable medical equipment which has no personal use in the absence of the condition for which prescribed; (13) diagnostic x-rays and laboratory tests as defined by the commissioner; (14) oral surgery for: (A) Excision of partially or completely unerupted impacted teeth, or (B) excision of a tooth root without the extraction of the entire tooth; (15) services of a licensed physical therapist, rendered under the direction of a physician; (16) transportation by a local professional ambulance to the nearest health care institution qualified to treat the illness or injury; (17) certain other services which are medically necessary in the treatment or diagnosis of an illness or injury as may be designated or approved by the Insurance Commissioner;

(18) confinement in a facility established primarily for the treatment of alcoholism and licensed for such care by the state, or in a part of a hospital used primarily for such treatment, shall be a covered expense for a period of at least forty-five days within any calendar year.

(b) Minimum standard benefits may include one or more of the following provisions: (1) For policies issued or renewed prior to April 1, 1994, subject to the provisions of subdivision (3) such plan may require deductibles. The "low option deductible" shall be two hundred dollars per person, the "middle option deductible" shall be five hundred dollars per person, and the "high option deductible" shall be seven hundred fifty dollars per person. The amount of the deductible may not be greater when a service is rendered on an outpatient basis than when that service is offered on an inpatient basis. Expenses incurred during the last three months of a calendar year and actually applied to an individual's deductible for that year shall be applied to that individual's deductible in the following calendar year. The two-hundred-dollar maximum, the five-hundred-dollar maximum and the seven-hundred-fifty-dollar maximum may be adjusted yearly to correspond with the change in the medical care component of the Consumer Price Index, as adjusted by the commissioner. The base year for such computation shall be the first full year of operation of such plan. (2) For policies issued or renewed prior to April 1, 1994, subject to the provisions of subdivision (3), such plan shall require a maximum copayment of twenty per cent for charges for all types of health care in excess of the deductible and fifty per cent for services listed in subdivision (3) of subsection (a) in excess of the deductible. (3) The sum of any deductible and copayments required in any calendar year may not exceed a maximum limit of one thousand dollars per covered individual, or two thousand dollars per covered family; provided, covered expenses incurred after the applicable maximum limit has been reached shall be paid at the rate of one hundred per cent, except that expenses incurred for treatment of mental and nervous conditions may be paid at the rate of fifty per cent as specified in subdivision (3) of subsection (a). The one-thousand-dollar and two-thousand-dollar maximums shall be adjusted yearly to correspond with the change in the medical care component of the Consumer Price Index as adjusted by the commissioner. (4) The plan shall limit benefits with respect to each pregnancy, other than a pregnancy involving complications of pregnancy, to a maximum of two hundred fifty dollars. (5) The plan may limit lifetime benefits to a maximum of not less than one million dollars per covered individual. (6) No preexisting condition exclusion shall exclude coverage of any preexisting condition unless: (A) The condition first manifested itself within the

period of six months immediately prior to the effective date of coverage in such a manner as would cause a reasonably prudent person to seek diagnosis, care or treatment; (B) medical advice or treatment was recommended or received within the period of six months immediately prior to the effective date of coverage; or (C) the condition is pregnancy existing on the effective date of coverage. No policy shall exclude coverage for a loss due to preexisting conditions for a period greater than twelve months following the effective date of coverage. Any individual comprehensive health care plan issued as a result of conversion from group health insurance or from a self-insured group shall credit the time covered under such group health insurance toward any such exclusion.

(c) Plans providing minimum standard benefits need not provide benefits for the following: (1) Any charge for any care for any injury or disease either (A) arising out of and in the course of an employment subject to a workers' compensation or similar law or where such benefit is required to be provided under a workers' compensation policy to a sole proprietor, business partner or corporation officer who elects such coverage pursuant to the provisions of chapter 568, or (B) to the extent benefits are payable without regard to fault under a coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance; (2) any charge for treatment for cosmetic purposes other than surgery for the prompt repair of an accidental injury sustained while covered, provided cosmetic shall not mean replacement of any anatomic structure removed during treatment of tumors; (3) any charge for travel, other than transportation by local professional ambulance to the nearest health care institution qualified to treat the illness or injury; (4) any charge for private room accommodations to the extent it is in excess of the institution's most common charge for a semiprivate room; (5) any charge by health care institutions to the extent that it is determined by the carrier that the charge exceeds the rates approved by the Office of Health Care Access division of the Department of Public Health; (6) any charge for services or articles to the extent that it exceeds the reasonable charge in the locality for the service; (7) any charge for services or articles which are determined not to be medically necessary, except that this shall not apply to the fabrication or placement of the prosthesis as specified in subdivision (11) of subsection (a) of this section and subdivision (2) of this subsection; (8) any charge for services or articles the provisions of which is not within the scope of the license or certificate of the institution or individual rendering such services or articles; (9) any charge for services or articles furnished, paid for or reimbursed directly by or under any law of a government, except as otherwise

provided in this subsection; (10) any charge for services or articles for custodial care or designed primarily to assist an individual in meeting his activities of daily living; (11) any charge for services which would not have been made if no insurance existed or for which the covered individual is not legally obligated to pay; (12) any charge for eyeglasses, contact lenses or hearing aids or the fitting thereof; (13) any charge for dental care not specifically covered by sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive; and (14) any charge for services of a registered nurse who ordinarily resides in the covered individual's home, or who is a member of the covered individual's family or the family of the covered individual's spouse.

(d) and (e) Repealed by P.A. 84-499, S. 2.

(f) The minimum standard benefits of any individual or group comprehensive health care plan may be satisfied by catastrophic coverage offered in conjunction with basic hospital or medical-surgical plans on an expense incurred or service basis as approved by the commissioner as providing at least equivalent benefits.

(g) Comprehensive health care plan carriers may offer alternative policy provisions and benefits, including cost containment features, consistent with the purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, provided such alternative provisions and benefits are approved by the Insurance Commissioner prior to their use. Cost containment features may include, but shall not be limited to, preferred provider provisions; utilization review of health care services, including review of the medical necessity of hospital and physician services; case management benefit alternatives; and other managed care provisions.

(h) Every comprehensive health care plan issued or renewed through the Health Reinsurance Association on or after April 1, 1994, shall be a managed care plan. Such managed care plans shall include one or more health care center plans or preferred provider network plans, as determined by the board of the association, with the approval of the commissioner. In the event that such managed care plans would not adequately serve enrollees in a particular area of the state, the board may offer to such enrollees a managed care product which contains alternative cost containment features, including but not limited to, utilization review of health care services, review of the medical necessity of hospital and physician services and case management benefit alternatives.

(i) No comprehensive health care plan issued through the Health Reinsurance Association to a HIPAA eligible individual shall include any limitation or exclusion of benefits based on a preexisting condition.]

[(j)] No [comprehensive] health care plan issued through the Health Reinsurance Association to a health care tax credit eligible individual shall include any limitation or exclusion of benefit based on a preexisting condition if such individual maintained creditable health insurance coverage for an aggregate period of three months as of the date on which the individual seeks to enroll in the Health Reinsurance Association issued plan, not counting any period prior to a sixty-three-day break in coverage.

[(k) (1) Each comprehensive health care plan issued through the Health Reinsurance Association shall provide coverage, under the terms and conditions of the plan, for the preexisting conditions of any group member or dependent who is newly insured under the plan on or after October 1, 2005, and was previously covered for such preexisting condition under the terms of the group member's or dependent's preceding qualifying coverage, provided the preceding qualifying coverage was continuous to a date less than one hundred twenty days prior to the effective date of the new coverage, exclusive of any applicable waiting period, except in the case of a newly insured group member whose preceding qualifying coverage was terminated due to an involuntary loss of employment, the preceding qualifying coverage must have been continuous to a date not more than one hundred fifty days prior to the effective date of the new coverage under the plan, exclusive of any applicable waiting period, provided the requirements of this subdivision shall only apply if the newly insured group member or dependent applies for such succeeding coverage not later than thirty days after the first day of the member's or dependent's initial eligibility.

(2) With respect to a group member or dependent who was newly insured under the plan on or after October 1, 2005, and was previously covered under qualifying coverage, but was not covered under such qualifying coverage for a preexisting condition, as defined under the newly issued comprehensive health care plan, such plan shall credit the time such group member or dependent was previously covered by qualifying coverage to the exclusion period of the preexisting condition provision, provided the preceding qualifying coverage was continuous to a date less than one hundred twenty days prior to the effective date of the new coverage, exclusive of

any applicable waiting period under such plan, except in the case of a newly insured group member whose preceding qualifying coverage was terminated due to an involuntary loss of employment, the preceding qualifying coverage must have been continuous to a date not more than one hundred fifty days prior to the effective date of the new coverage, exclusive of any applicable waiting period, provided the requirements of this subdivision shall only apply if such newly insured group member or dependent applies for such succeeding coverage not later than thirty days after the first day of the member's or dependent's initial eligibility.

(3) As used in this subsection, "qualifying coverage" means coverage under (A) any group health insurance plan, group insurance arrangement or self-insured plan covering a group, (B) Medicare or Medicaid, or (C) an individual health insurance planthat provides benefits which are actuarially equivalent to or exceeding the benefits provided under a small employer health care plan, as defined in section 38a-564, whether issued in this state or any other state, as determined by the Insurance Department.]

Section 13. Section 38a-554 of the general statutes is repealed (Effective from passage):

[A group comprehensive health care plan shall contain the minimum standard benefits prescribed in section 38a-553 and shall also conform in substance to the requirements of this section.

(a) The plan shall be one under which the individuals eligible to be covered include: (1) Each eligible employee; (2) the spouse of each eligible employee, who shall be considered a dependent for the purposes of this section; and (3) unmarried children who are under twenty-six years of age. Each plan shall cover a stepchild on the same basis as a biological child.

(b) The plan shall provide the option to continue coverage under each of the following circumstances until the individual is eligible for other group insurance, except as provided in subdivisions (3) and (4) of this subsection:

(1) Notwithstanding any provision of this section, upon layoff, reduction of hours, leave of absence or termination of employment, other than as a result of death of

the employee or as a result of such employee's "gross misconduct" as that term is used in 29 USC 1163(2), continuation of coverage for such employee and such employee's covered dependents for a period of thirty months after the date of such layoff, reduction of hours, leave of absence or termination of employment, except that if such reduction of hours, leave of absence or termination of employment results from an employee's eligibility to receive Social Security income, continuation of coverage for such employee and such employee's covered dependents until midnight of the day preceding such person's eligibility for benefits under Title XVIII of the Social Security Act;

(2) Upon the death of the employee, continuation of coverage for the covered dependents of such employee for the periods set forth for such event under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended from time to time;

(3) Regardless of the employee's or dependent's eligibility for other group insurance, during an employee's absence due to illness or injury, continuation of coverage for such employee and such employee's covered dependents during continuance of such illness or injury or for up to twelve months from the beginning of such absence;

(4) Regardless of an individual's eligibility for other group insurance, upon termination of the group plan, coverage for covered individuals who were totally disabled on the date of termination shall be continued without premium payment during the continuance of such disability for a period of twelve calendar months following the calendar month in which the plan was terminated, provided claim is submitted for coverage within one year of the termination of the plan;

(5) The coverage of any covered individual shall terminate: (A) As to a child, the plan shall provide the option for said child to continue coverage for the longer of the following periods: (i) At the end of the month following the month in which the child: Marries; ceases to be a resident of the state; becomes covered under a group health plan through the dependent's own employment; or attains the age of twenty-six. The residency requirement shall not apply to dependent children under nineteen years of age or full-time students attending an accredited institution of higher education. If on the date specified for termination of coverage on a child, the child is unmarried and incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the employee for support and maintenance, the coverage on such child shall continue while the plan remains in

force and the child remains in such condition, provided proof of such handicap is received by the carrier within thirty-one days of the date on which the child's coverage would have terminated in the absence of such incapacity. The carrier may require subsequent proof of the child's continued incapacity and dependency but not more often than once a year thereafter, or (ii) for the periods set forth for such child under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended from time to time; (B) as to the employee's spouse, at the end of the month following the month in which a divorce, court-ordered annulment or legal separation is obtained, whichever is earlier, except that the plan shall provide the option for said spouse to continue coverage for the periods set forth for such events under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended from time to time; and (C) as to the employee or dependent who is sixty-five years of age or older, as of midnight of the day preceding such person's eligibility for benefits under Title XVIII of the federal Social Security Act;

(6) As to any other event listed as a "qualifying event" in 29 USC 1163, as amended from time to time, continuation of coverage for such periods set forth for such event in 29 USC 1162, as amended from time to time, provided such plan may require the individual whose coverage is to be continued to pay up to the percentage of the applicable premium as specified for such event in 29 USC 1162, as amended from time to time.

Any continuation of coverage required by this section except subdivision (4) or (6) of this subsection may be subject to the requirement, on the part of the individual whose coverage is to be continued, that such individual contribute that portion of the premium the individual would have been required to contribute had the employee remained an active covered employee, except that the individual may be required to pay up to one hundred two per cent of the entire premium at the group rate if coverage is continued in accordance with subdivision (1), (2) or (5) of this subsection. The employer shall not be legally obligated by sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, to pay such premium if not paid timely by the employee.

(c) The commissioner shall adopt regulations, in accordance with chapter 54, concerning coordination of benefits between the plan and other health insurance

plans. No individual or group health insurance plan shall coordinate benefits or otherwise reduce benefit payments because a person is covered by or receives benefits from a group specified disease policy delivered, issued for delivery, renewed, amended or continued in this state.

(d) The plan shall make available to Connecticut residents, in addition to any other conversion privilege available, a conversion privilege under which coverage shall be available immediately upon termination of coverage under the group plan. The terms and benefits offered under the conversion benefits shall be at least equal to the terms and benefits of an individual comprehensive health care plan.

(e) (1) The provisions of subdivision (1) of subsection (b) of this section shall apply to any individual for whom such continuation of coverage is in effect or who elects continuation of coverage pursuant to this section, on or after May 5, 2010.

(2) Each insurer and health care center that has issued a group health insurance policy subject to sections 38a-546 and 38a-554 shall, in conjunction with their group policyholders, including employers with fewer than twenty employees, provide notice of the continuation of coverage period specified in subdivision (1) of subsection (b) of this section to such individuals set forth in subdivision (1) of this subsection not later than sixty days after May 5, 2010.]

Section 14. Section 38a-555 of the general statutes is repealed (Effective from passage):

[An individual comprehensive health care plan shall contain the minimum standard benefits prescribed in section 38a-553, including the choice of the low option, middle option or high option deductible, and shall also conform in substance to the requirements of this section. Each individual comprehensive health care plan shall contain provisions: (1) Which obligate the carrier to continue the contract until the earlier of (A) the date on which the individual in whose name the contract was issued first becomes eligible for coverage under Title XVIII of the Social Security Act, provided the individual is sixty-five years of age or older, or under a group comprehensive health care plan, or (B) the plan anniversary date at least sixty days prior to which the carrier has mailed to the individual at his last address shown on the carrier's records written notice of its decision not to continue coverage on a class

basis only, or (C) the date on which the individual becomes eligible for coverage under a health insurance high risk pool or arrangement established by statute or regulation in another state. The carrier may reserve the right to adjust premiums by classes in accordance with its experience for policies or contracts not written by or through the Health Reinsurance Association, provided such premium may not exceed the premium established for that particular class by the Health Reinsurance Association; (2) which, upon the death of the individual in whose name the contract was issued, permits every other individual then covered under the contract to elect, within such period as shall be specified in the contract, to continue the same coverage until such time as he would have ceased to be entitled to coverage had the individual in whose name the contract was issued lived; and (3) under which the benefits payable shall be excess to all other sources of health insurance benefits, including benefits provided pursuant to any state or federal law other than Medicaid.]

Section 15. Section 38a-556 of the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

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 (a) of this section, and shall exercise its powers through a board of directors established under this section.

(a) (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 [consistent with the date on which the coverage under sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, must be made available. The commissioner shall, after notice and hearing, approve the plan of operation provided such plan is determined to be suitable to assure the fair, reasonable and equitable administration of the association, and provides for the sharing of association gains or losses on an equitable proportionate basis. If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, or if at any time thereafter the board fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section]. Such [rules] <u>plan</u> 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[, in addition to requirements enumerated in sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive]: (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;[(H) establish procedures for the advertisement on behalf of all participating carriers of the general availability of the comprehensive coverage under sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive; (I) contain additional provisions necessary for the association to qualify as an acceptable alternative mechanism in accordance with Section 2744 of the Public Health Service Act, as set forth in the Health Insurance

Portability and Accountability Act of 1996, P.L. 104-191;] and [(J)] (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] Trade Adjustment Assistance programs of the Trade Act of 2002, P.L. 107-210, and other programs that may be established. [The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to establish criteria for the association to qualify as an acceptable alternative mechanism.]

(b) 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 sections [38a-505, 38a-546 and] 38a-551 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 [on an indemnity or provision of service basis providing the coverage] required or permitted by sections [38a-505, 38a-546 and] 38a-551 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; and (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.

(c) [Every member shall participate in the association in accordance with the provisions of this subsection. (1) A participating member shall determine the particular risks it elects to have written by or through the association. A member shall designate which of the following classes of risks it shall underwrite in the state, from which classes of risk it may elect to reinsure selected risks: (A) Individual, excluding group conversion; and (B) individual, including group conversion. (2) No member shall be permitted to select out individual lives from an employer group to be insured by or through the association. Members electing to administer risks that are insured by or through the association shall comply with the benefit determination guidelines and the accounting procedures established by the association. A risk insured by or through the association cannot be withdrawn by the participating member except in accordance with the rules established by the association. (3)] Rates for coverage issued by or through the association shall not be excessive, inadequate or unfairly discriminatory. [Separate scales of premium rates based on age shall apply, but rates shall not be adjusted for area variations in provider costs. Premium rates shall take into consideration the substantial extra morbidity and administrative expenses for association risks, reimbursement or reasonable expenses incurred for the writing of association risks and the level of rates charged by insurers for groups of ten lives, provided incurred losses that result from provision of coverage in accordance with section 38a-537 shall not be considered. In no event shall the rate for a given classification or group be less than one hundred twenty-five per cent or more than one hundred fifty per cent of the average rate charged for that classification with similar characteristics under a policy covering ten lives.] 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 from the filing thereof if excessive, inadequate or unfairly discriminatory.

(d) (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. [(4) For the fiscal year ending December 31, 1993, and the first quarter of the fiscal year ending December 31, 1994, the administrator shall not include health care centers in assessing any net losses to participating members.]

(e) 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 sections 38a-505, [38a-546] and 38a-551 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 which are unfair or deceptive or which encourage misrepresentation of the policy.

(f) Unless otherwise permitted by the plan of operation, the association shall not issue, reissue or continue in force [comprehensive] health care plan coverage with respect to any person who is already covered under an individual or group [comprehensive] health care plan <u>issued by the Health Reinsurance Association</u>, or who is sixty-five years of age or older and eligible for Medicare or who is not a resident of this state. Coverage provided to a [HIPAA or] health care tax credit eligible individual may be terminated to the extent permitted by [HIPAA or] the Trade Act of 2002[, respectively].

(g) Benefits payable under a [comprehensive] 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, Medicare, but excluding Medicaid.

(h) 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 his representatives for any action taken by them in the performance of their duties under sections [38a-505, 38a-546 and] 38a-551 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 [comprehensive] health care plan.

Section 16. Section 38a-564 of the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

As used in this section and sections 12-201, 12-211, 12-212a and 38a-565 to 38a-572, inclusive:

(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) ["Eligible employee"] <u>Employee</u> means [an employee who works a normal work week of twenty or more hours and includes a sole proprietor, a partner of a partnership or an independent contractor, provided such sole proprietor, partner or contractor is included as an employee under a health care plan of a small employer but does not include an employee who works on a seasonal, temporary or substitute basis. "Eligible employee" shall include any employee who is not actively at work but is covered under the small employer's health insurance plan pursuant to (A) workers' compensation, (B) continuation of benefits pursuant to section 38a-554, or (C) other

applicable laws.] any individual employed by an employer, except that for purposes of this section, (A) an individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse, and (B) a partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership.

(4) (A) "Small employer" means [any person, firm, corporation, limited liability company, partnership or association actively engaged in business or self-employed for at least three consecutive months who, on at least fifty per cent of its working days during the preceding twelve months, employed no more than fifty eligible employees, the majority of whom were employed within the state of Connecticut. "Small employer" includes a self-employed individual.] *, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. For plan years beginning on or after January 1, 2016 the number of employees is increased from 50 to100 employees during the preceding calendar year* . The number of employees of an employer shall be determined by adding: (i) the number of full time employees that work at least thirty hours per week; and (ii) the number of full time equivalent employees calculated for a particular month by dividing the aggregate number of hours of service of employees who are not full time employees for the month divided by 120. [For the purposes of determining the number of eligible employees under this subdivision: (i) Companies that are affiliated companies, as defined in section 33-840, or that are eligible to file a combined tax return for purposes of taxation under chapter 208 shall be considered one employer; (ii) employees covered through the employer by health insurance plans or insurance arrangements issued to or in accordance with a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act shall not be counted; (iii) employees who are not actively at work but are covered under the small employer's health insurance plan pursuant to workers' compensation, continuation of benefits pursuant to section 38a-554 or other applicable laws shall

not be counted; and (iv) employees who work a normal work week of less than thirty hours shall not be counted. Except as otherwise specifically provided, provisions of this section and sections 12-201, 12-211, 12-212a and 38a-565 to 38a-572, inclusive, that apply to a small employer shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this definition.]

(B) "Small employer" does not include [(i) municipality procuring health insurance pursuant to section 5-259, (ii) a private school in this state procuring health insurance through a health insurance plan or an insurance arrangement sponsored by an association of such private schools, (iii) a nonprofit organization procuring health insurance pursuant to section 5-259, unless the Secretary of the Office of Policy and Management and the State Comptroller make a request in writing to the Insurance Commissioner that such nonprofit organization be deemed a small employer for the purposes of this chapter, (iv) an association for personal care assistants procuring health insurance pursuant to section 5-259, or (v) a community action agency procuring health insurance pursuant to section 5-259.] a sole proprietor whose only employees include the sole proprietor or spouse.

(C) All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer

(D) In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(5) "Insurer" means any insurance company, hospital or 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 (ERISA), 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 and 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 that 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) "Late enrollee" means an eligible employee or dependent who requests enrollment in a small employer's health insurance plan following the initial enrollment period provided under the terms of the first plan for which such employee or dependent was eligible through such small employer, provided an eligible employee or dependent shall not be considered a late enrollee if (A) the request for enrollment is made within thirty days after termination of coverage provided under another group health insurance plan and if the individual had not initially requested coverage under such plan solely because he was covered under another group health insurance plan and coverage under that plan has ceased due to termination of employment, death of a spouse, or divorce, or due to that plan's involuntary termination or cancellation by its carrier for reasons other than nonpayment of premium, or (B) the individual is employed by an employer who offers multiple health insurance plans and the individual elects a different health

insurance plan during an open enrollment period, or (C) a court has ordered coverage be provided for a spouse or minor child under a covered employee's plan and request for enrollment is made within thirty days after issuance of such court order, or (D) if the request for enrollment is made within thirty days after the marriage of such employee or the birth or adoption of the first child by such employee after the later of the commencement of the employer's plan or the date the pool becomes operational, and satisfactory evidence of such marriage, birth or adoption is provided to the small employer carrier.]

[(10)] (9) "Department" means the Insurance Department.

[(11) "Special health care plan" means a health insurance plan for previously uninsured small employers, established by the board in accordance with section 38a-565 or by the Health Reinsurance Association in accordance with section 38a-570.

(12) "Small employer health care plan" means a health insurance plan for small employers, established by the board in accordance with section 38a-568.]

[(13)] (10) "Dependent" means the spouse or child of an [eligible] employee, subject to applicable terms of the health insurance plan covering such employee. "Dependent" shall also include any dependent that is covered under the small employer's health insurance plan pursuant to workers' compensation, continuation of benefits pursuant to section [38a-554] 38a-512a or other applicable laws.

[(14)] (11) "Commissioner" means the Insurance Commissioner.

[(15)](12) "Member" means each insurer and insurance arrangement participating in the pool.

[(16)] (13) "Small employer carrier" means any insurer or insurance arrangement which offers or maintains group health insurance plans covering [eligible] employees of one or more small employers.

[(17) "Preexisting conditions provision" means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage as to a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinary prudent person to seek diagnosis, care or

treatment or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition.

(18) "Base premium rate" means, as to any health insurance plan or insurance arrangement covering one or more employees of a small employer, the lowest new business premium rate charged by the insurer or insurance arrangement for the same or similar coverage which is equivalent in value under a plan or arrangement covering any small employer with similar case characteristics, other than claim experience, as determined by such insurer or insurance arrangement, except that as to any small employer carrier or insurance arrangement not issuing new health insurance plans or insurance arrangements to a small employer, "base premium rate" means the lowest rate charged a small employer for the same or similar coverage which is equivalent in value, under a plan or arrangement covering any small employer with similar case characteristics, other than claim experience, as determined by such insurer or insurance arrangement.

(19) "Low-income eligible employee" means an eligible employee of a small employer whose annualized wages from such small employer determined as of the effective date of the special health care plan or as of any anniversary of such effective date as certified to the insurer or insurance arrangement or the Health Reinsurance Association, as the case may be, by such small employer is less than three hundred per cent of the federal poverty level applicable to such person.

(20) "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended from time to time.

(21) "Health Reinsurance Association" means the entity established and maintained in accordance with the provisions of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive.

(22) "Reimbursement rate" means, as to individuals covered under special health care plans or an individual special health care plan, seventy-five per cent of the Medicare reimbursement rate for benefits normally reimbursable under Medicare. For services or supplies not reimbursed by Medicare, such reimbursement shall be seventy-five per cent of the amount which would be payable under Medicare, if Medicare was responsible for benefit payments under such plans for such services and supplies, as determined by the board and approved by the commissioner.

(23) "Individual special health care plan" means a health insurance plan for individuals, issued by the Health Reinsurance Association in accordance with section 38a-571 or issued by an insurer in accordance with section 38a-565.

(24) "Low-income individual" means an individual whose adjusted gross income (AGI) for the individual and spouse, from the most recent federal tax return filed prior to the date of application for the individual special health care plan or prior to any anniversary of the effective date of the plan, as certified by such individual, is less than three hundred per cent of the applicable federal poverty level.

(25) "Medicare reimbursement rate" means the amount which would be payable under Medicare for benefits normally reimbursed under Medicare.]

[(26)](14) "Health care center" means health care center as defined in section 38a-175.

[(27)](15) "Case characteristics" means demographic or other objective characteristics of a small employer, including age[, sex, family composition,] and geographic location.[, size of group, administrative cost savings resulting from the administration of an association group plan or a plan written pursuant to section 5-259 and industry classification, as determined by a small employer carrier, that are considered by the small employer carrier in the determination of premium rates for the small employer.] Claim experience, health status, and duration of coverage since issue are not case characteristics for the purpose of sections 38a-564 to 38a-572, inclusive.

[(28) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of subdivisions (4), (6), (7) and (9) of section 38a-567 and the regulations promulgated by the commissioner pursuant to section 38a-567, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.]

Section 17. Section 38a-565 of the general statutes is repealed (Effective from passage):

[(a)(1) In order to facilitate the provision of lower cost health insurance coverage for uninsured small employers, the board shall establish, subject to the approval of the commissioner, special health care plans for use by the Health Reinsurance Association. The board shall submit such plans to the commissioner for the commissioner's approval. The board shall take into consideration the levels of health care plans provided in Connecticut and such medical and economic factors as may be deemed appropriate and shall establish benefit levels, deductibles, coinsurance factors, maximum copayment obligations and exclusions and limitations which the board considers appropriate for uninsured small employers, provided the level of reimbursement shall be based on the reimbursement rate. Such plans may include cost containment features such as, but not limited to: (A) Preferred provider provisions; (B) utilization review of health care services, including review of medical necessity of hospital and physician services; (C) case management benefit alternatives; and (D) other managed care provisions.

(2) After the commissioner's approval of special health care plans submitted by the board pursuant to subdivision (1) of this subsection, and in lieu of the procedure established by section 38a-481, the Health Reinsurance Association may certify to the commissioner, in the form and manner prescribed by the commissioner, that the special health care plans filed by said association are in substantial compliance with the provisions in the corresponding approved board plan. Upon receipt by the department of such certification, said association may offer such certified plans until such time as the commissioner, after notice and hearing, disapproves their continued use.

(b) (1) Not later than ninety days after approval by the commissioner of the special health care plans submitted by the board, the Health Reinsurance Association shall offer small employers such plans. Except as provided in subdivision (2) of this subsection, every small employer that elects to be covered under a special health care plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued such a plan by the Health Reinsurance Association.

(2) No small employer shall be eligible to purchase a special health care plan unless such employer had maintained no health insurance coverage for its employees at

any time during the one-year period ending on the date of application for such policy. No small employer shall purchase a special health care plan for more than three years.

(c) Insurers may issue individual special health care plans subject to the laws applicable to individual health insurance in this state, provided such policies shall be identical to the individual special health care plans made available by the Health Reinsurance Association pursuant to section 38a-571.]

Section 18. Section 38a-566 of the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

(a) Any individual or group health insurance plan or any insurance arrangement shall be subject to the provisions of sections 12-201, 12-211, 12-212a and 38a-564 to 38a-572, inclusive, if it provides health insurance or is an insurance arrangement covering one or more employees of a small employer and if any one of the following conditions are met:

(1) Any portion of the premium or benefits is paid by a small employer or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium; or

(2) The health insurance plan or arrangement is treated by the employer or any of the covered individuals as part of a plan or program for the purposes of Section 162 or Section 106 of the United States Internal Revenue Code.

(b) Nothing in this section shall be construed to apply the provisions of sections 12-202 and 12-212a to health care centers.

(c) Notwithstanding the provisions of subsection (a) of this section, health insurance plans or insurance arrangements issued to or in accordance with a trust established pursuant to collective bargaining, subject to the federal Labor Management Relations Act and which cover, in the aggregate, more than twenty-five employees of all participating employers, shall not be subject to the provisions of section 38a-567 or subparagraph (A) of subdivision (2) of subsection (e) of section 38a-569 and insurers or insurance arrangements issuing only such plans shall not be considered small employer carriers for purposes of sections 38a-565 and 38a-568.

(d) A small employer carrier that ceases marketing to small employers as provided in subsection (d) of section 38a-568 shall not cease enrolling new employers in a policy issued to provide coverage to the members of a trade association or to a trust on behalf of a trade association if the following conditions exist:

(1) Such trade association is a not-for-profit trade association qualified under 26 USC Section 501c(6), was not formed solely for the purpose of providing insurance and has been operating continuously for at least twenty-five years.

(2) The policy issued to or on behalf of such association was in existence prior to June 1, 1990, and has annual premiums of less than twenty-five million dollars.

(3) Such policy is offered on a guaranteed issue basis to all small employer members and only to members of such trade association.

[(e) Subsection (a) of this section shall not apply to an individual health insurance plan issued to a self-employed individual if the carrier discloses on the application and marketing materials, in not less than ten-point type, the following notice: "THIS PLAN IS ISSUED ON AN INDIVIDUAL BASIS AND IS REGULATED AS AN INDIVIDUAL HEALTH INSURANCE PLAN."]

Section 19. Section 38a-567 of the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

Health insurance plans, associations of small employers and other insurance arrangements covering small employers and insurers and producers marketing such plans and arrangements shall be subject to the following provisions:

(1) (A) [(i)] Any such [insurer or producer marketing such plans or arrangements shall offer premium quotes to small employers upon request for coverage for employees who work a normal work week of thirty or more hours. Upon request by a small employer, such insurer or producer shall offer premium quotes for coverage for employees that include those who work a normal work week of at least twenty hours.

(ii) No small employer that has requested premium quotes for coverage for employees that include those who work a normal work week of less than thirty hours

shall be required to accept such quotes or coverage in lieu of premium quotes or coverage for only those employees who work a normal work week of thirty or more hours.

(iii) Nothing in this subparagraph shall require a small employer that offers coverage to its employees who work a normal work week of thirty hours or more to offer coverage to its employees who work a normal work week of less than thirty hours.] plan or arrangement shall be offered on a guaranteed issue basis with respect to all eligible employees or dependents at the option of the small employer, policyholder or contractholder, as the case may be.

(B) Any such plan or arrangement shall be renewable with respect to all eligible employees or dependents at the option of the small employer, policyholder or contractholder, as the case may be, except: (i) For nonpayment of the required premiums by the small employer, policyholder or contractholder; (ii) for fraud or misrepresentation of the small employer, policyholder or contractholder or, with respect to coverage of individual insured, the insureds or their representatives; (iii) for noncompliance with plan or arrangement provisions; (iv) when the number of insureds covered under the plan or arrangement is less than the number of insureds or percentage of insureds required by participation requirements under the plan or arrangement; or (v) when the small employer, policyholder or contractholder is no longer actively engaged in the business in which it was engaged on the effective date of the plan or arrangement.

(C) Renewability of coverage may be effected by either continuing in effect a plan or arrangement covering a small employer or by substituting upon renewal for the prior plan or arrangement the plan or arrangement then offered by the carrier that most closely corresponds to the prior plan or arrangement and is available to other small employers. Such substitution shall only be made under conditions approved by the commissioner. A carrier may substitute a plan or arrangement as stated above only if the carrier effects the same substitution upon renewal for all small employers previously covered under the particular plan or arrangement, unless otherwise approved by the commissioner. The substitute plan or arrangement shall be subject to the rating restrictions specified in this section on the same basis as if no substitution had occurred, except for an adjustment based on coverage differences.

[(D) Notwithstanding the provisions of this subdivision, any such plan or arrangement, or any coverage provided under such plan or arrangement may be

rescinded for fraud, intentional material misrepresentation or concealment by an applicant, employee, dependent or small employer.

(E) Any individual who was not a late enrollee at the time of his or her enrollment and whose coverage is subsequently rescinded shall be allowed to reenroll as of a current date in such plan or arrangement subject to any preexisting condition or other provisions applicable to new enrollees without previous coverage. On and after the effective date of such individual's reenrollment, the small employer carrier may modify the premium rates charged to the small employer for the balance of the current rating period and for future rating periods, to the level determined by the carrier as applicable under the carrier's established rating practices had full, accurate and timely underwriting information been supplied when such individual initially enrolled in the plan. The increase in premium rates allowed by this provision for the balance of the current rating period shall not exceed twenty-five per cent of the small employer's current premium rates. Any such increase for the balance of said current rating period shall not be subject to the rate limitation specified in subdivision (6) of this section. The rate limitation specified in this section shall otherwise be fully applicable for the current and future rating periods. The modification of premium rates allowed by this subdivision shall cease to be permitted for all plans and arrangements on the first rating period commencing on or after July 1, 1995.

(2) Except in the case of a late enrollee who has failed to provide evidence of insurability satisfactory to the insurer, the plan or arrangement may not exclude any eligible employee or dependent who would otherwise be covered under such plan or arrangement on the basis of an actual or expected health condition of such person. No plan or arrangement may exclude an eligible employee or eligible dependent who, on the day prior to the initial effective date of the plan or arrangement, was covered under the small employer's prior health insurance plan or arrangement pursuant to workers' compensation, continuation of benefits pursuant to section 38a-554 or other applicable laws. The employee or dependent must request coverage under the new plan or arrangement on a timely basis and such coverage shall terminate in accordance with the provisions of the applicable law.

(3) (A) For rating periods commencing on or after October 1, 1993, and prior to July 1, 1994, the premium rates charged or offered for a rating period for all plans and

arrangements may not exceed one hundred thirty-five per cent of the base premium rate for all plans or arrangements.

(B) For rating periods commencing on or after July 1, 1994, and prior to July 1, 1995, the premium rates charged or offered for a rating period for all plans or arrangements may not exceed one hundred twenty per cent of the base premium rate for such rating period. The provisions of this subdivision shall not apply to any small employer who employs more than twenty-five eligible employees.

(4) For rating periods commencing on or after October 1, 1993, and prior to July 1, 1995, the percentage increase in the premium rate charged to a small employer, who employs not more than twenty-five eligible employees, for a new rating period may not exceed the sum of:

(A) The percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(B) An adjustment of the small employer's premium rates for the prior rating period, and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer, such adjustment (i) not to exceed ten per cent annually for the rating periods commencing on or after October 1, 1993, and prior to July 1, 1994, and (ii) not to exceed five per cent annually for the rating periods commencing on or after July 1, 1994, and prior to July 1, 1995; and

(C) Any adjustments due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's applicable rate manual.

(5) (A)] (2)(A) With respect to non-grandfathered plans or arrangements issued to small employers [on or after July 1, 1995], the premium rates charged or offered [to small employers] shall be established on the basis of a [community rate] single pool of all non-grandfathered plans, adjusted to reflect one or more of the following classifications:

(i) Age[, provided age brackets of less than five years shall not be utilized] in accordance with a uniform age rating curve established by the commissioner; and

[(ii) Gender;]

[(iii)] (ii) Geographic area[, provided an area smaller than a county shall not be utilized;] as defined by the commissioner; and

(iii) Tobacco use, except that such rate may not vary by more than 1.5 to 1 and may only be applied with respect to individuals who may legally use tobacco under federal and state law. For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco.

(B) With respect to grandfathered plans or arrangements issued to small employers, the premium rates charged or offered shall be established on the basis of a single pool of all grandfathered plans, adjusted to reflect one or more of the following classifications:

(i) Age in accordance with a uniform age rating curve established by the commissioner;

(ii) Geographic area as defined by the commissioner; and

(iii) Tobacco use, except that such rate may not vary by more than 1.5 to 1 and may only be applied with respect to individuals who may legally use tobacco under federal and state law. For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco.

(C) Grandfathered and non-grandfathered plans have the meaning as defined in the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and regulations adopted thereunder.

(D) The premium rate for any given plan may vary by actuarially justified differences in plan design.

(E) The total premium for family coverage must be determined by summing the premiums for each individual family member. With respect to family members under the age of 21, the premiums for no more than the three oldest covered children must be taken into account in determining the total family premium.

(F) The premium rate for any given plan may vary by actuarially justified amounts to reflect the plan's provider network and administrative expense differences that can be reasonably allocated to that plan.

(G) Premium rates for employees and dependents shall be calculated on a per member basis, and the premium rate for the small employer group shall be calculated by totally the premiums attributable to each covered individual.

[(iv) Industry, provided the rate factor associated with any industry classification shall not vary from the arithmetic average of the highest and lowest rate factors associated with all industry classifications by greater than fifteen per cent of such average, and provided further, the rate factors associated with any industry shall not be increased by more than five per cent per year;

(v) Group size, provided the highest rate factor associated with group size shall not vary from the lowest rate factor associated with group size by a ratio of greater than 1.25 to 1.0;

(vi) Administrative cost savings resulting from the administration of an association group plan or a plan written pursuant to section 5-259, provided the savings reflect a reduction to the small employer carrier's overall retention that is measurable and specifically realized on items such as marketing, billing or claims paying functions taken on directly by the plan administrator or association, except that such savings may not reflect a reduction realized on commissions;

(vii) Savings resulting from a reduction in the profit of a carrier who writes small business plans or arrangements for an association group plan or a plan written pursuant to section 5-259 provided any loss in overall revenue due to a reduction in profit is not shifted to other small employers; and

(viii) Family composition, provided the small employer carrier shall utilize only one or more of the following billing classifications: (I) Employee; (II) employee plus family; (III) employee and spouse; (IV) employee and child; (V) employee plus one dependent; and (VI) employee plus two or more dependents.

(B) The small employer carrier shall quote premium rates to small employers after receipt of all demographic rating classifications of the small employer group. No small employer carrier may inquire regarding health status or claims experience of

the small employer or its employees or dependents prior to the quoting of a premium rate.

(C) The provisions of subparagraphs (A) and (B) of this subdivision shall apply to plans or arrangements issued on or after July 1, 1995. The provisions of subparagraphs (A) and (B) of this subdivision shall apply to plans or arrangements issued prior to July 1, 1995, as of the date of the first rating period commencing on or after that date, but no later than July 1, 1996.

(6) For any small employer plan or arrangement on which the premium rates for employee and dependent coverage or both, vary among employees, such variations shall be based solely on age and other demographic factors permitted under subparagraph (A) of subdivision (5) of this section and such variations may not be based on health status, claim experience, or duration of coverage of specific enrollees. Except as otherwise provided in subdivision (1) of this section, any adjustment in premium rates charged for a small employer plan or arrangement to reflect changes in case characteristics prior to the end of a rating period shall not include any adjustment to reflect the health status, medical history or medical underwriting classification of any new enrollee for whom coverage begins during the rating period.

(7) For rating periods commencing prior to July 1, 1995, in any case where a small employer carrier utilized industry classification as a case characteristic in establishing premium rates, the rate factor associated with any industry classification shall not vary from the arithmetical average of the highest and lowest rate factors associated with all industry classifications by greater than fifteen per cent of such average.

(8) Differences in base premium rates charged for health benefit plans by a small employer carrier shall be reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans.

(9) For rating periods commencing prior to July 1, 1995, in any case where an insurer issues or offers a policy or contract under which premium rates for a specific small employer are established or adjusted in part based upon the actual or expected variation in claim costs or actual or expected variation in health conditions of the employees or dependents of such small employer, the insurer shall make reasonable

disclosure of such rating practices in solicitation and sales materials utilized with respect to such policy or contract.

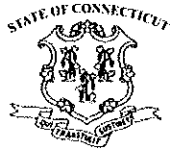
(10) If a small employer carrier denies coverage as requested to a small employer that is self-employed, the small employer carrier shall promptly offer such small employer the opportunity to purchase a small employer health care plan. If a small employer carrier or any producer representing that carrier fails, for any reason, to offer coverage as requested by a small employer that is self-employed, that small employer carrier shall promptly offer such small employer an opportunity to purchase a small employer health care plan.]

[(11)] (3) No small employer carrier or producer shall, directly or indirectly, engage in the following activities:

(A) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer[, except the provisions of this subparagraph shall not apply to information provided by a small employer carrier or producer to a small employer regarding the carrier's established geographic service area or a restricted network provision of a small employer carrier]; or

(B) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

[(12) No small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic area of the small employer. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a special or a small employer health care plan. No small employer carrier shall terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.]



[(13)] (4) No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

[(14) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reasons for the denial.]

[(15)] (5) No small employer carrier or producer shall disclose (A) to a small employer the fact that any or all of the eligible employees of such small employer have been or will be reinsured with the pool, or (B) to any eligible employee or dependent the fact that he has been or will be reinsured with the pool.

[(16)] (6) If a small employer carrier enters into a contract, agreement or other arrangement with another party to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the other party shall be subject to the provisions of this section.

[(17)] (7) The commissioner may adopt regulations in accordance with the provisions of chapter 54 setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers.

[(18) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles. Each small employer carrier shall file with the commissioner annually, on or before March fifteenth, an actuarial certification certifying that the carrier is in compliance with this part and that the rating methods have been derived using recognized actuarial principles consistent with the provisions of sections 38a-564 to 38a-573, inclusive. Such certification shall be in a form and manner and shall contain such information as determined by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business. Any information and documentation described in this subdivision but not subject to the filing requirement shall be made available to the commissioner upon his request. Except in cases of violations of sections 38a-564 to 38a-573, inclusive, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the

commissioner to persons outside of the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

(19) The commissioner may suspend all or any part of this section relating to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that either the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

(20) For rating periods commencing prior to July 1, 1995, a small employer carrier shall quote premium rates to any small employer within thirty days after receipt by the carrier of such employer's completed application.]

[(21)] (8) Any violation of subdivisions [(10) to (16)] (3) to (6), inclusive, of this section and of any regulations established under subdivision [(17)] (7) of this section shall be an unfair and prohibited practice under sections 38a-815 to 38a-830, inclusive.

[(22) (A) With respect to plans or arrangements issued pursuant to subsection (i) of section 5-259, at the option of the Comptroller, the premium rates charged or offered to small employers purchasing health insurance shall not be subject to this section, provided (i) the plan or plans offered or issued cover such small employers as a single entity and cover not less than three thousand employees on the date issued, (ii) each small employer is charged or offered the same premium rate with respect to each employee and dependent, and (iii) the plan or plans are written on a guaranteed issue basis.

(B) With respect to plans or arrangements issued by an association group plan, at the option of the administrator of the association group plan, the premium rates charged or offered to small employers purchasing health insurance shall not be subject to this section, provided (i) the plan or plans offered or issued cover such small employers as a single entity and cover not less than three thousand employees on the date issued, (ii) each small employer is charged or offered the same premium rate with respect to each employee and dependent, and (iii) the plan or plans are written on a guaranteed issue basis. In addition, such association group (I) shall be a bona fide group as set forth in the Employee Retirement and Security Act of 1974, (II) shall not be formed for the purposes of fictitious grouping, as defined in section 38a-827, and

(III) shall not issue any plan that shall cause undue disruption in the insurance marketplace, as determined by the commissioner.]

Section 20. Section 38a-568 of the general statutes is repealed (Effective from passage):

[(a)(1) Subject to approval by the commissioner, the board shall establish the form and level of coverages to be made available by small employer carriers in accordance with the provisions of subsection (b) of this section. Such coverages, which shall be designated as small employer health care plans, shall be limited to: (A) A basic hospital plan, (B) a basic surgical plan, (C) major medical plans which can be written in conjunction with basic hospital plans or basic surgical plans, (D) comprehensive plans, and (E) plans with benefit and cost-sharing levels which are consistent with the basic method of operation and the benefit plans of health care centers, including any restrictions imposed by federal law. The board shall submit such plans to the commissioner for the commissioner's approval not later than ninety days after the appointment of the board pursuant to section 38a-569. The board shall take into consideration the levels of health insurance provided in Connecticut and such medical and economic factors as may be deemed appropriate and shall establish benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of health insurance provided to small employers. Such plans may include cost containment features including, but not limited to: (i) Preferred provider provisions; (ii) utilization review of health care services, including review of medical necessity of hospital and physician services; (iii) case management benefit alternatives; and (iv) other managed care provisions.

(2) After the commissioner's approval of small employer health care plans submitted by the board pursuant to subdivision (1) of this subsection, and in lieu of the procedure established by section 38a-513, any small employer carrier may certify to the commissioner, in the form and manner prescribed by the commissioner, that the small employer health care plans filed by the carrier are in substantial compliance with the provisions in the corresponding approved board plan. Upon receipt by the department of such certification, the carrier may use such certified plans until such time as the commissioner, after notice and hearing, disapproves their continued use.

(b) Not later than ninety days after the commissioner's approval of small employer health care plans submitted by the board, each small employer carrier, including, but not limited to, each health care center, shall, as a condition of transacting such insurance in this state, offer those small employer health care plans that correspond to the insurance products being currently offered by the carrier to small employers. Each small employer that elects to be covered under such plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued such a plan by the small employer carrier.

(c) No health care center shall be required to offer coverage or accept applications pursuant to subsection (b) of this section in the case of any of the following: (1) To a group, where the group is not physically located in the health care center's approved service area; (2) to an employee, where the employee does not work or reside within the health care center's approved service area; (3) within an area, where the health care center reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within that area in its network of providers to deliver services adequately to the members of such groups because of its obligations to existing group contract holders and enrollees; (4) where the commissioner finds that acceptance of an application or applications would place the health care center in an impaired financial condition; or (5) where the commissioner finds that compliance with subsection (b) or (f) of this section would place the health care center in an impaired financial condition. A health care center that refuses to offer coverage pursuant to subdivision (3) of this subsection may not, for ninety days after such refusal, offer coverage in the applicable area to new cases of employer groups with more than twenty-five eligible employees.

(d) A small employer carrier shall not be required to offer coverage or accept applications pursuant to subsection (b) of this section subject to the following conditions: (1) The small employer carrier ceases to market health insurance or health benefit plans to small employers and ceases to enroll small employers under existing health insurance or health benefit plans; (2) the small employer carrier notifies the commissioner of its decision to cease marketing to small employers and to cease enrolling small employers, as provided in subdivision (1) of this subsection; and (3) the small employer carrier is prohibited from reentering the small employer market for a period of five years from the date of the notice required under subdivision (2) of this subsection.

(e) For groups containing only one member, a small employer carrier or health care center offering coverage pursuant to this section may require proof that the individual has been self-employed for three consecutive months.

(f) Each small employer carrier, including, but not limited to, a health care center, shall offer each health care plan that the carrier makes available to small employers, except association group plans, to all small employers, including, but not limited to, groups containing only one member.]

Section 21. Section 38a-569 of the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

(a)(1) There is established a nonprofit entity to be known as the "Connecticut Small Employer Health Reinsurance Pool". All insurers issuing health insurance in this state and insurance arrangements providing health plan benefits in this state on and after July 1, 1990, shall be members of the pool.

(2) On or before July 15, 1990, the commissioner shall give notice to all insurers and insurance arrangements of the time and place for the initial organizational meeting, which shall take place by September 1, 1990. The members shall select the initial board, subject to approval by the commissioner. The board shall consist of at least five and not more than nine representatives of members. There shall be no more than two members of the board representing any one insurer or insurance arrangement. In determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. The vote shall be weighted based upon net health insurance premium derived from this state in the previous calendar year. To the extent possible, at least one-third of the members of the board shall be domestic insurance companies and at least two-thirds of the members of the board shall be small employer carriers. At least one member of the board shall be a health care center and at least one member shall be a small employer carrier with less than one hundred million dollars in net small employer health insurance premium in this state. The Insurance Commissioner shall be an ex-officio member of the board. The net premium amount shall be adjusted by the board periodically for health care cost inflation. In approving selection of the board, the commissioner shall assure that all members are fairly represented. The membership of all boards

subsequent to the initial board shall, to the extent possible, reflect the same distribution of representation as is described in this subdivision.

(3) If the initial board is not elected at the organizational meeting, the commissioner shall appoint the initial board within fifteen days of the organizational meeting.

(4) Within ninety days after the appointment of such initial board, the board shall submit to the commissioner a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. The commissioner shall, after notice and hearing, approve the plan of operation provided he determines it to be suitable to assure the fair, reasonable and equitable administration of the pool, and provides for the sharing of pool gains or losses on an equitable proportionate basis in accordance with the provisions of subsection (d) of this section. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this section shall be made available. If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, or at any time thereafter fails to submit suitable amendments to the plan of operation, the commissioner shall, after notice and hearing, adopt and promulgate a plan of operation or amendments, as appropriate. The commissioner shall amend any plan adopted by him, as necessary, at the time a plan of operation is submitted by the board and approved by the commissioner.

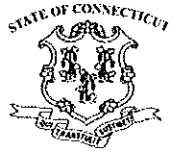
(5) The plan of operation shall establish procedures for: (A) Handling and accounting of assets and moneys of the pool, and for an annual fiscal reporting to the commissioner; (B) filling vacancies on the board, subject to the approval of the commissioner; (C) selecting an administrator and setting forth the powers and duties of the administrator; (D) reinsuring risks in accordance with the provisions of this section; (E) collecting assessments from all members to provide for claims reinsured by the pool and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made; and (F) any additional matters at the discretion of the board.

(6) The pool shall have the general powers and authority granted under the laws of Connecticut to insurance companies licensed to transact health insurance and, in addition thereto, the specific authority to: (A) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this section, including the authority, with the approval of the commissioner, to enter into contracts with

programs of other states for the joint performance of common functions, or with persons or other organizations for the performance of administrative functions; (B) sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against members; (C) take such legal action as necessary to avoid the payment of improper claims against the pool; (D) define the array of health coverage products for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this section; (E) establish rules, conditions and procedures pertaining to the reinsurance of members' risks by the pool; (F) establish appropriate rates, rate schedules, rate adjustments, rate classifications and any other actuarial functions appropriate to the operation of the pool; (G) assess members in accordance with the provisions of subsection (e) of this section, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any such interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year; (H) appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool; and (I) borrow money to effect the purposes of the pool. Any notes or other evidence of indebtedness of the pool not in default shall be legal investments for insurers and may be carried as admitted assets.

(b) Any member may reinsure with the pool coverage of an eligible employee of a small employer, or any dependent of such an employee <u>whose plan is subject to section 38a-567.</u> [, except that no member may reinsure with the pool coverage of an eligible employee of a small employer, or any dependent of such an employee, whose premium rates are not subject to section 38a-567 pursuant to subdivision (22) of section 38a-567. Any reinsurance placed with the pool from the date of the establishment of the pool regarding the coverage of an eligible employee of a small employer, or any dependent of such an employee shall be provided as follows:

(1) (A) With respect to a special health care plan or a small employer health care plan, the pool shall reinsure the level of coverage provided; (B) with respect to other plans, the pool shall reinsure the level of coverage provided up to, but not exceeding, the level of coverage provided in a small employer health care plan or the actuarial equivalent thereof as defined and authorized by the board; and (C) in either case, no reinsurance may be provided in any calendar year for a reinsured employee or dependent until five thousand dollars in benefit payments have been made for



services provided during that calendar year for that reinsured employee or dependent, which payments would have been reimbursed through said reinsurance in the absence of the annual five-thousand-dollar deductible. The amount of the deductible shall be periodically reviewed by the board and may be adjusted for appropriate factors as determined by the board;

(2) With respect to eligible employees, and their dependents, coverage may be reinsured: (A) Within such period of time after the commencement of their coverage under the plan as may be authorized by the board, or (B) commencing January 1, 1992, on the first plan anniversary after the employer's coverage has been in effect with the small employer carrier for a period of three years, and every third plan anniversary thereafter, provided, commencing May 1, 1994, reinsurance pursuant to this subparagraph shall only be permitted with respect to eligible employees and their dependents of a small employer which has no more than two eligible employees as of the applicable anniversary;

(3) Reinsurance coverage may be terminated for each reinsured employee or dependent on any plan anniversary;

(4) Reinsurance of newborn dependents shall be allowed only if the mother of any such dependent is reinsured as of the date of birth of such child, and all newborn dependents of reinsured persons shall be automatically reinsured as of their date of birth; and

(5) Notwithstanding the provisions of subparagraph (A) of subdivision (2) of this subsection: (A) Coverage for eligible employees and their dependents provided under a group policy covering two or more small employers shall not be eligible for reinsurance when such coverage is discontinued and replaced by a group policy of another carrier covering two or more small employers, unless coverage for such eligible employees or dependents was reinsured by the prior carrier; and (B) at the time coverage is assumed for such group by a succeeding carrier, such carrier shall notify the pool of its intention to provide coverage for such group and shall identify the employees and dependents whose coverage will continue to be reinsured. The time limitations for providing such notice shall be established by the pool.

(c) Except as provided in subsection (d) of this section, premium rates charged for reinsurance by the pool shall be established at the following percentages of the rate

established by the pool for that classification or group with similar characteristics and coverage:

(1) One hundred fifty per cent, with respect to all of the eligible employees, and their dependents, of a small employer, all of whose coverage is reinsured in accordance with subdivision (2) of subsection (b) of this section; and

(2) Five hundred per cent, with respect to an eligible employee or dependent who is individually reinsured in accordance with subdivision (2) of subsection (b) of this section and is not reinsured with all eligible employees of an employer and their dependents.

(d) Premium rates charged for reinsurance by the pool to a health care center which is approved by the Secretary of Health and Human Services as a health maintenance organization pursuant to 42 USC 300 et seq., and as such is subject to requirements that limit the amount of risk that may be ceded to the pool, may be modified by the board, if appropriate, to reflect the portion of risk that may be ceded to the pool.]

[(e)] (c) (1) Following the close of each fiscal year, the administrator shall determine the net premiums, the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. For purposes of this section, health insurance premiums earned by insurance arrangements shall be established by adding paid health losses and administrative expenses of the insurance arrangement. Health insurance premiums and benefits paid by a member that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments. For purposes of this subsection, "net premiums" means health insurance premiums, less administrative expense allowances.

(2) Any net loss for the year shall be recouped by assessments of members. (A) Assessments shall first be apportioned by the board among all members in proportion to their respective shares of the total health insurance premiums earned in this state from health insurance plans and insurance arrangements covering small employers during the calendar year coinciding with or ending during the fiscal year of the pool, or on any other equitable basis reflecting coverage of small employers as may be provided in the plan of operations. An assessment shall be made pursuant to this subparagraph against a health care center, which is approved by the Secretary of Health and Human Services as a health maintenance organization pursuant to 42

USC 300e et seq., subject to an assessment adjustment formula adopted by the board and approved by the commissioner for such health care centers which recognizes the restrictions imposed on such health care centers by federal law. Such adjustment formula shall be adopted by the board and approved by the commissioner prior to the first anniversary of the pool's operation. (B) If such net loss is not recouped before assessments totaling five per cent of such premiums from plans and arrangements covering small employers have been collected, additional assessments shall be apportioned by the board among all members in proportion to their respective shares of the total health insurance premiums earned in this state from other individual and group plans and arrangements, exclusive of any individual Medicare supplement policies as defined in section 38a-495 during such calendar year. (C) Notwithstanding the provisions of this subdivision, the assessments to any one member under subparagraph (A) or (B) of this subdivision shall not exceed forty per cent of the total assessment under each subparagraph for the first fiscal year of the pool's operation and fifty per cent of the total assessment under each subparagraph for the second fiscal year. Any amounts abated pursuant to this subparagraph shall be assessed against the other members in a manner consistent with the basis for assessments set forth in this subdivision.

(3) If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

(4) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with it. Insurance arrangements shall report to the board claims payments made and administrative expenses incurred in this state on an annual basis on a form prescribed by the commissioner.

(5) Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of assessments.

(6) The board may defer, in whole or in part, the assessment of a health care center if, in the opinion of the board: (A) Payment of the assessment would endanger the ability of the health care center to fulfill its contractual obligations, or (B) in accordance with standards included in the plan of operation, the health care center has written, and reinsured in their entirety, a disproportionate number of special

health care plans. In the event an assessment against a health care center is deferred in whole or in part, the amount by which such assessment is deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in this subsection. The health care center receiving such deferment shall remain liable to the pool for the amount deferred. The board may attach appropriate conditions to any such deferment.

(f) (1) Neither the participation in the pool as members, the establishment of rates, forms or procedures nor any other joint or collective action required by this section shall be the basis of any legal action, criminal or civil liability or penalty against the pool or any of its members.

(2) Any person or member made a party to any action, suit or proceeding because the person or member served on the board or on a committee or was an officer or employee of the pool shall be held harmless and be indemnified by the program against all liability and costs, including the amounts of judgments, settlements, fines or penalties, and expenses and reasonable attorney's fees incurred in connection with the action, suit or proceeding. The indemnification shall not be provided on any matter in which the person or member is finally adjudged in the action, suit or proceeding to have committed a breach of duty involving gross negligence, dishonesty, wilful misfeasance or reckless disregard of the responsibilities of office. Costs and expenses of the indemnification shall be prorated and paid for by all members. The Insurance Commissioner may retain actuarial consultants necessary to carry out said commissioner's responsibilities pursuant to sections 38a-564 to 38a-572, inclusive, and such expenses shall be paid by the pool established in this section.

Section 22. Section 38a-570 of the general statutes is repealed (Effective from passage):

[Notwithstanding the provisions of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, the Health Reinsurance Association may issue special health care plans to small employers with ten or fewer eligible employees, the majority of whom are low-income eligible employees. The following provisions shall apply to such special health care plans:

(1) Premium rates shall be promulgated by the board of directors of the Health Reinsurance Association based on recommendations of its actuarial committee. In developing recommendations for premium rates, the actuarial committee shall consider, in addition to other pertinent matters, the premiums that are or would be charged for the same or similar insurance by other insurers. Except as otherwise provided in sections 38a-564 to 38a-572, inclusive, in establishing premium rates the board of directors of the Health Reinsurance Association may consider any relevant factors impacting premium, claims and expenses, including characteristics of small employers and insureds, that may be considered by any insurer in establishing health insurance premium rates. The premium rates established shall be subject to the provisions of section 38a-567. The anticipated loss ratio shall not be less than eighty per cent of the premium. In establishing premium rates the board of directors of the Health Reinsurance Association shall administer special health care plans issued to small employers without gain or loss; and

(2) The Health Reinsurance Association may reinsure coverage of special health care plans with the pool.]

Section 23. Section 38a-571of the general statutes is repealed (Effective from passage):

[In addition to the options for individual comprehensive health care plans, the Health Reinsurance Association shall make available to individuals, on the same terms and conditions as are applicable to the other individual comprehensive health care plan options under sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, including the provisions for establishment and filing of premium rates, the option to purchase an individual special health care plan identical to the special health care plan for small employers established in accordance with section 38a-565. The requirement that coverage not have been maintained for a one-year period contained in subdivision (2) of subsection (b) of section 38a-565 shall not apply to individual special health care plans.]

Section 24. Section 38a-572 of the general statutes is repealed (Effective from passage):

[No individual or organization that provides medical advice, diagnosis, care or treatment of a type covered under a special health care plan, as defined in section 38a-565 or 38a-570, shall, on or after July 1, 1990, provide such service to any person in this state unless such individual or organization provides such service, upon request, on the basis of the applicable reimbursement rate, to low-income eligible employees or their dependents covered under such special health care plans or low income individuals or their dependents covered under individual special health care plans, as defined in section 38a-571.]

Section 25. Section 38a-574 of the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

Sec. 38a-574. [Standard underwriting form] Family Health Statement. (a) [On or before July 1, 1993, the] The board of directors of the Connecticut Small Employer Health Reinsurance Pool shall establish, subject to the approval of the Insurance Commissioner, a standard [underwriting form] family health statement for use by small employer carriers for [medical underwriting of health insurance plans and insurance arrangements covering small employers, as defined in section 38a-564] use in determining whether to cede lives to the reinsurance pool. Within ninety days after approval by the Insurance Commissioner of the standard underwriting form the board shall require every small employer carrier, as a condition of transacting such business in this state, to use the form for [medical underwriting of] such plans and arrangements.

(b) The form may be amended from time to time as the board deems necessary, subject to the approval of the Insurance Commissioner.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID1101LongTermCareHealthInsurance

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Insurance Department

Liaison: Jim Perras
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E-mail: jim.perras.ct.gov

Lead agency division requesting this proposal:
Life and Health

Agency Analyst/Drafter of Proposal:
Mary Ellen Breault, Tim Lyons

Title of Proposal
An Act Concerning Long Term Care Health Insurance Premium Rate Increases

Statutory Reference
Sections 38-501 and 38a-528

Proposal Summary

Section 1. This proposed change amends section 38a-501 concerning rate filings for individual long term care insurance policies. Filings for rate increases must include an option to spread any rate increase approved over a period of at least 3 years. The insurance company or other entity issuing the policy must provide the policyholder with 30 days advance notice of the policyholder's options to (1) pay the increase in full; (2) pay the rate increase over 3 years or longer, or (3) reduce the benefits.

Section 2. This proposed change concerns rate filings for group long term care insurance policies. It provides the same 3 options described in Section 1. for group certificate holders covered under group long term care policies.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? ***No***

(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)

(3) Have certain constituencies called for this action? ***Policyholders have experienced significant rate increases***

(4) *What would happen if this was not enacted in law this session?* ***Policyholders would have to absorb the rate increase all at once or reduce their benefits to a premium level that is acceptable***

- **Origin of Proposal** **__X_ New Proposal** **___ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Office of Policy Management
Agency Contact : David Guttchen, Director, Conn. Partnership for Long Term Care, 860-418-6318
Date Contacted: September 24, 2013

Approve of Proposal __X_ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

The Insurance Department and OPM have been working jointly on this proposal.

It provides options for insured individuals covered under Partnership policies as well as other long term care policies covering Conn. residents.

Will there need to be further negotiation? ___ YES __X_NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)

N/A

State

N/A

Federal N/A
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

If enacted, this proposal would require carriers to inform individual policy holders that they can spread out the cost of a rate increase over a period of no less than three years.

Section 1. Section 38a-501 of the general statutes is repealed and the following is substituted in lieu thereof (effective October1, 2014):

Sec. 38a-501. (a)(1) As used in this section, "long-term care policy" means any individual health insurance policy delivered or issued for delivery to any resident of this state on or after July 1, 1986, that is designed to provide, within the terms and conditions of the policy, benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for at least one year after an elimination period (A) not to exceed one hundred days of confinement, or (B) of over one hundred days but not to exceed two years of confinement, provided such period is covered by an irrevocable trust in an amount estimated to be sufficient to furnish coverage to the grantor of the trust for the duration of the elimination period. Such trust shall create an unconditional duty to pay the full amount held in trust exclusively to cover the costs of confinement during the elimination period, subject only to taxes and any trustee's charges allowed by law. Payment shall be made directly to the provider. The duty of the trustee may be enforced by the state, the grantor or any person acting on behalf of the grantor. A long-term care policy shall provide benefits for confinement in a nursing home or confinement in the insured's own home or both. Any additional benefits provided shall be related to long-term treatment of an injury, illness or loss of functional

capacity. "Long-term care policy" shall not include any such policy that is offered primarily to provide basic Medicare supplement coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage or limited benefit health coverage.

(2) (A) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any long-term care policy in this state may refuse to accept or make reimbursement pursuant to a claim for benefits submitted by or prepared with the assistance of a managed residential community, as defined in section 19a-693, in accordance with subdivision (7) of subsection (a) of section 19a-694 solely because such claim for benefits was submitted by or prepared with the assistance of a managed residential community.

(B) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any long-term care policy in this state shall, upon receipt of a written authorization executed by the insured, (i) disclose information to a managed residential community for the purpose of determining such insured's eligibility for an insurance benefit or payment, and (ii) provide a copy of the initial acceptance or declination of a claim for benefits to the managed residential community at the same time such acceptance or declination is made to the insured.

(b) (1)No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center may deliver or issue for delivery any long-term care policy that has a loss ratio of less than sixty per cent for any individual long-term care policy. An issuer shall not use or change premium rates for a long-term care insurance policy unless the rates have been filed with and approved by the Insurance Commissioner. Any rate filings or rate revisions shall demonstrate that anticipated claims in relation to premiums when combined with actual experience to date can be expected to comply with the loss ratio requirement of this section. A rate filing shall include the factors and methodology used to estimate irrevocable trust values if the policy includes an option for the elimination period specified in subdivision (1) of subsection (a) of this section.

(2)(i) Any rate filing for increases on in-force business must include at least one option to spread the rate increase over a period of not less than 3 years. The periodic rate increases shall be actuarially equivalent to the single rate increase. The interest rate used shall be a current rate for the period chosen.

(ii) Each such company, society, corporation or center shall give policyholders a minimum of 30 days notice of their options to accept the full increase, accept the periodic increase or reduce the policy benefits to reduce the premium. Any benefit reductions shall be calculated on an actuarial equivalent basis.

(c) No such company, society, corporation or center may deliver or issue for delivery any long-term care policy without providing, at the time of solicitation or application for purchase or sale of such coverage, full and fair disclosure of the benefits and limitations of the policy. If the offering for any long-term care policy includes an option for the elimination period specified in subdivision (1) of subsection (a) of this section, the application form for such policy and the face page of such policy shall contain a clear and conspicuous disclosure that the irrevocable trust may not be sufficient to cover all costs during the elimination period.

(d) No such company, society, corporation or center may deliver or issue for delivery any long-term care policy on or after July 1, 2008, without offering, at the time of solicitation or application for purchase or sale of such coverage, an option to purchase a policy that includes a nonforfeiture benefit. Such offer of a nonforfeiture benefit may be in the form of a rider attached to such policy. In the event the nonforfeiture benefit is declined, such company, society, corporation or center shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates. Not later than July 1, 2008, the Insurance Commissioner shall adopt regulations, in accordance with chapter 54, to implement the provisions of this subsection. Such regulations shall specify the type of nonforfeiture benefit that may be offered, the standards for such benefit, the period of time during which a contingent benefit upon lapse will be available and the substantial increase in premium rates that trigger a contingent benefit upon lapse in accordance with the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners.

(e) The Insurance Commissioner shall adopt regulations, in accordance with chapter 54, that address (1) the insured's right to information prior to his replacing an accident and sickness policy with a long-term care policy, (2) the insured's right to return a long-term care policy to the insurer, within a specified period of time after delivery, for cancellation, and (3) the insured's right to accept by the insured's signature, and prior to it becoming effective, any rider or endorsement added to a long-term care policy after the issuance date of such policy. The Insurance Commissioner shall adopt such additional regulations as the commissioner deems necessary in accordance with chapter 54 to carry out the purpose of this section.

(f) The Insurance Commissioner may, upon written request by any such company, society, corporation or center, issue an order to modify or suspend a specific provision of this section or any regulation adopted pursuant thereto with respect to a specific long-term care policy upon a written finding that: (1) The modification or suspension would be in the best interest of the insureds; (2) the purposes to be achieved could not be effectively or efficiently achieved without such modification or suspension; and (3) (A) the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care, (B) the policy is to be issued to residents of a life care or continuing care retirement community or other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such community, or (C) the modification or suspension is necessary to permit long-term care policies to be sold as part of, or in conjunction with, another insurance product. Whenever the commissioner decides not to issue such an order, the commissioner shall provide written notice of such decision to the requesting party in a timely manner.

(g) Upon written request by any such company, society, corporation or center, the Insurance Commissioner may issue an order to extend the preexisting condition exclusion period, as established by regulations adopted pursuant to this section, for purposes of specific age group categories in a specific long-term care policy form whenever the commissioner makes a written finding that such an extension is in the best interest to the public. Whenever the commissioner decides not to issue such an order, the commissioner shall provide written notice of such decision to the requesting party in a timely manner.

(h) The provisions of section 38a-19 shall be applicable to any such requesting party aggrieved by any order or decision of the commissioner made pursuant to subsections (f) and (g) of this section.

Section 2. Section 38a-528 of the general statutes is repealed and the following is substituted in lieu thereof (effective October 1, 2014):

Sec. 38a-528. (a)(1) As used in this section, "long-term care policy" means any group health insurance policy or certificate delivered or issued for delivery to any resident of this state on or after July 1, 1986, which is designed to provide, within the terms and conditions of the policy or certificate, benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for at least one year after a reasonable elimination period. A long-term care policy shall provide benefits for confinement in a nursing home or

confinement in the insured's own home or both. Any additional benefits provided shall be related to long-term treatment of an injury, illness or loss of functional capacity. "Long-term care policy" shall not include any such policy or certificate which is offered primarily to provide basic Medicare supplement coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage or limited benefit health coverage.

(2) (A) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any long-term care policy in this state may refuse to accept or make reimbursement pursuant to a claim for benefits submitted by or prepared with the assistance of a managed residential community, as defined in section 19a-693, in accordance with subdivision (7) of subsection (a) of section 19a-694 solely because such claim for benefits was submitted by or prepared with the assistance of a managed residential community.

(B) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any long-term care policy in this state shall, upon receipt of a written authorization executed by the insured, (i) disclose information to a managed residential community for the purpose of determining such insured's eligibility for an insurance benefit or payment, and (ii) provide a copy of the initial acceptance or declination of a claim for benefits to the managed residential community at the same time such acceptance or declination is made to the insured.

(b)(1) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center may deliver or issue for delivery any long-term care policy or certificate which has a loss ratio of less than sixty-five per cent for any group long-term care policy. An issuer shall not use or change premium rates for a long-term care insurance policy or certificate unless the rates have been filed with the Insurance Commissioner. Deviations in rates to reflect policyholder experience shall be permitted, provided each policy form shall meet the loss ratio requirement of this section. Any rate filings or rate revisions shall demonstrate that anticipated claims in relation to premiums when combined with actual experience to date can be expected to comply with the loss ratio requirement of this section. On an annual basis, an insurer shall submit to the Insurance Commissioner an actuarial certification of the insurer's continuing compliance with the loss ratio requirement of this section. Any rate or rate revision may be disapproved if the commissioner

determines that the loss ratio requirement will not be met over the lifetime of the policy form using reasonable assumptions.

(2)(i) Any rate filing for increases on in-force business must include at least one option to spread the rate increase over a period of not less than 3 years. The periodic rate increases shall be actuarially equivalent to the single rate increase. The interest rate used shall be a current rate for the period chosen.

(ii) Each such company, society, corporation or center shall give certificateholders a minimum of 30 days notice of their options to accept the full increase, accept the periodic increase or reduce the policy benefits to reduce the premium. Any benefit reductions shall be calculated on an actuarial equivalent basis.

(c) No such company, society, corporation or center may deliver or issue for delivery any long-term care policy without providing, at the time of solicitation or application for purchase or sale of such coverage, full and fair disclosure of the benefits and limitations of the policy. The provisions of this subsection shall not be applicable to: (1) Any long-term care policy which is delivered or issued for delivery to one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, or the labor organizations; and (2) noncontributory plans.

(d) The Insurance Commissioner shall adopt regulations, in accordance with chapter 54, which address (1) the insured's right to information prior to his replacing an accident and sickness policy with a long-term care policy, (2) the insured's right to return a long-term care policy to the insurer, within a specified period of time after delivery, for cancellation, and (3) the insured's right to accept by his signature, and prior to it becoming effective, any rider or endorsement added to a long-term care policy after the issuance date of such policy, provided (A) any regulations adopted pursuant to subdivisions (1) and (2) of this subsection shall not be applicable to (i) any long-term care policy which is delivered or issued for delivery to one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof or for members or former members or a combination thereof, of the labor organizations, or (ii) noncontributory plans, and (B) any regulations adopted pursuant to subdivision (3) of this subsection shall not be applicable to any group long-term policy. The Insurance Commissioner shall adopt such additional regulations as he deems necessary in accordance with said chapter 54 to carry out the purpose of this section.

(e) The Insurance Commissioner may, upon written request by any such company, society, corporation or center, issue an order to modify or suspend a specific provision of this section or any regulation adopted pursuant thereto with respect to a specific long-term care policy upon a written finding that: (1) The modification or suspension would be in the best interest of the insureds; (2) the purposes to be achieved could not be effectively or efficiently achieved without such modification or suspension; and (3) (A) the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care, (B) the policy is to be issued to residents of a life care or continuing care retirement community or other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such community, or (C) the modification or suspension is necessary to permit long-term care policies to be sold as part of, or in conjunction with, another insurance product, whenever the commissioner decides not to issue such an order, he shall provide written notice of such decision to the requesting party in a timely manner.

(f) Upon written request by any such company, society, corporation or center, the Insurance Commissioner may issue an order to extend the preexisting condition exclusion period, as established by regulations adopted pursuant to this section, for purposes of specific age group categories in a specific long-term care policy form whenever he makes a written finding that such an extension is in the best interest to the public. Whenever the commissioner decides not to issue such an order, he shall provide written notice of such decision to the requesting party in a timely manner.

(g) The provisions of section 38a-19 shall be applicable to any such requesting party aggrieved by any order or decision of the commissioner made pursuant to subsections (e) and (f) of this section.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID1101MarketConductAuthority.doc
(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Connecticut Insurance Department

Liaison: Jim Perras
Phone: (860) 297-3864
E-mail: jim.perras@ct.gov

Lead agency division requesting this proposal: Market Conduct Division

Agency Analyst/Drafter of Proposal: Beth Cook
092313

Title of Proposal
An Act Concerning Market Conduct Authority

Statutory Reference 38a-15

Proposal Summary
This amends 38a-15 (market conduct statute) with respect to costs of exams, use of consultants paid by the regulated entity, payment for out of state travel by the examined entity, and work paper confidentiality.

This allows the Insurance Department to charge foreign and domestic insurance companies for the cost of consultants used as additional resources for the market conduct examination, and ensure that the work papers reviewing during those exams remain confidential.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
No

(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
Yes, most other states have similar language in their statute.

(3) Have certain constituencies called for this action?
The industry supports everything except for the chargeback.

(4) What would happen if this was not enacted in law this session?
We could not chargeback the cost of consultants used with domestic companies to the companies being examined. This limits the number and frequency of resources available to conduct market conduct exams. The lack of this ability, along with some of the other

protections put our statutes out of sync for multi-states and limits the Connecticut Insurance Department's ability to participate as the "lead state" in a multi-state exam of a Connecticut domiciled company. Connecticut domiciled entities subject to a multi-state exam would be assessed by an out-of-state regulatory body that has been assigned to be the "lead state". Other state's internal processes regarding the use and oversight of consultants may not be as restricting as the Connecticut Insurance Department's and as a result our domiciled entities may end up paying more.

- **Origin of Proposal ___ New Proposal __X_ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
Chargeback to industry for consultants was an issue.

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal? **Yes**

(3) *Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?* **Pro: Sen. Cisco & CID. Con: IAC & CTAHP**

(4) What was the last action taken during the past legislative session?
Insurance and Real Estate Committee passed the bill; passed in the Senate; died on the House Calendar

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency) **N/A**

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) N/A
State N/A
Federal N/A

Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

If enacted, this legislation will permit the Department to be the lead state in a multi-state market conduct exam for Connecticut domiciled businesses. Currently, because the Department does not have the authority to charge back costs of consultants and because it lacks confidentiality provisions in its market conduct exam statutes the Department must cede authority to another state in a multi-state exam even if the carrier being examined is domiciled in our state. Connecticut domiciled entities subject to a multi-state exam would be assessed by an out-of-state regulatory body that has been assigned to be the "lead state". Other state's internal processes regarding the use and oversight of consultants may not be as restricting as the Connecticut Insurance Department's and as a result our domiciled entities may end up paying more.

AN ACT CONCERNING INSURANCE DEPARTMENT EXAMINATIONS OF MARKET CONDUCT ACTIVITY.

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

Section 1. Section 38a-15 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) The commissioner shall, as often as the commissioner deems it expedient, undertake a market conduct examination of the affairs of any insurance company, health care center, third-party administrator, as defined in section 38a-720, or fraternal benefit society doing business in this state.

(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. Before filing such report, the commissioner shall grant a hearing to the company, center, administrator or society examined, and may withhold any such report from public inspection for such time as the commissioner deems proper. The commissioner may, if said 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) 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, and domestic insurance companies and other domestic entities examined outside the state shall pay the traveling and maintenance expenses of examiners.

(e) (1) The commissioner may engage the services of attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals or specialists as examiners to assist the commissioner in an examination under this section of a domestic insurance company or other domestic entity. The cost of such services shall be paid by such company or entity when the Insurance Department is the managing lead regulator in a multi-state examination or when the Commissioner initiates a targeted market conduct examination of the domestic insurance company or other domestic entity to investigate an alleged pattern of misconduct.

(2) No cause of action shall arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representative or any examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this section.

(3) 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 to the commissioner or the commissioner's authorized representative or examiner pursuant to an examination made under this section, if such act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(4) This section shall not abrogate or modify any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subdivision (2) of this subsection.

(f) Notwithstanding subdivision (1) of subsection (e) of this section, no domestic insurance company or other domestic entity subject to examination under this section shall pay, as costs associated with the examination, the salaries, fringe benefits and travel and maintenance expenses of examining personnel of the Insurance Department engaged in such examination if such company or entity is otherwise liable to an assessment levied under section 38a-47, except that a domestic insurance company or other domestic entity shall pay the travel and maintenance expenses of examining personnel of the Insurance Department when such company or entity is examined outside the state.

(g) Nothing in this section shall be construed to prevent or prohibit the commissioner from disclosing the content of an examination report, preliminary examination report or results or any matter relating thereto to (1) the insurance regulatory officials of this 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, at any time, provided such officials or agency receiving the report or matters relating thereto agrees, in writing, to hold such report or matters confidential.

(h) All working papers, 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 this section shall be given confidential treatment, 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. Access to such working papers, recorded information, documents and copies may be granted by the commissioner to the National Association of Insurance Commissioners as long as it agrees, in writing, to hold such working papers, recorded information, documents and copies confidential.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID1101GuarantyAssociations.doc

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Insurance Department

Liaison: Jim Perras
Phone: 860.297.3864
E-mail: jim.perras@ct.gov

Lead agency division requesting this proposal:
Connecticut Insurance Department / Legal Division

Agency Analyst/Drafter of Proposal:
Jon Arsenault

Title of Proposal
AAC the Connecticut Insurance Guaranty Association (CIGA) Act and the Connecticut Life and Health Insurance Guaranty Association (CLHIGA) Act

Statutory Reference: CIGA -- CONN. GEN. STAT. §§ 38a-836 to 38a-853 CLHIGA -- CONN. GEN. STAT. §§ 38a-858 to 38a-875

Proposal Summary

Sec. 1 amends CIGA Act definition of "insolvent insurer" to specify an insurer that is subject to a final order of liquidation with a finding of insolvency from the insurer's state of domicile, instead of current law which specifies an insurer determined to be insolvent by a court of competent jurisdiction, which may include instances when an insurer is placed into rehabilitation proceedings.

Sec. 2 amends CIGA Act (1) to provide coverage of covered claims existing prior to the order of liquidation and arising within 60 days after such order, instead of the current 30 days; (2) to increase the maximum coverage for claims (other than for workers' compensation) from $400,000 to $500,000 for insurers placed into liquidation with a finding of insolvency on or after October 1, 2014.

Sec. 3 amends the CLHIGA Act to expressly exclude CLHIGA coverage for contracts offering hospital, medical, prescription drugs or other health care benefits pursuant to Medicare Part C or D.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

Reason for Proposal: Sec. 1. The guaranty association statutes in most states define an insolvent insurer in terms of a final order of liquidation with a finding of insolvency. The CIGA Act currently does not require a final order of liquidation; only a declaration of insolvency by a court of competent jurisdiction. Section 1 will change the CIGA Act in response to the 2013 rehabilitation proceedings of Ullico Casualty Company (DE) which resulted in a court order (incorrectly drafted) that contained a finding of insolvency which triggered guaranty associations in several states including CIGA. The receiver suspended certain claim payments but did not have access to the claim files and basic

policyholder information to timely transmit the information to the affected guaranty associations that were statutorily triggered to protect affected policyholders.

Sec. 2. (1) The change from 30 to 60 days will give consumers more time to replace policies and CIGA will have more time to notify claimants of the insolvency, the applicable guaranty association coverage and the need to replace policies if necessary. The Ullico Casualty Insurance Company (DE) insolvency illustrated a situation when the guaranty associations are triggered but lack the records from the receivership (held by TPAs) in order to promptly and directly communicate with affected claimants.

(2) Raising the limit of coverage to $500,000 will offer additional protection to Connecticut residents and will be consistent with the NAIC Property and Casualty Insurance Guaranty Association Model Act level of coverage.

Sec. 3. (1) To conform the CLHIGA Act to the NAIC Life and Health Insurance Guaranty Association Model Act; (2) 37 states currently exclude claims under Medicare Parts C and D; (3) the proposal is a legislative resubmission - see sSB 1093 sec. 20 (2013 session).

Please consider the following, if applicable:

(1) *Have there been changes in federal/state/local laws and regulations that make this legislation necessary?* No.
(2) *Has this proposal or something similar been implemented in other states?* Yes. *If yes, what is the outcome(s)?* Greater uniformity.
(3) *Have certain constituencies called for this action?* Yes. Sec. 1 and 2(1) will help the administrators of CIGA. Sec. 3 is supported by CLHIGA.
(4) *What would happen if this was not enacted in law this session?* We would seek its enactment in the next session.

- **Origin of Proposal** **X__ New Proposal / Sec. 1 & 2** **X__ Resubmission / Sec. 3**

If this is a resubmission, please share:

(1) *What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?* In the 2013 session it was submitted to the legislature as part of the Department's Technical Revisions bill SB 1093. It passed the Senate unanimously and languished on the House calendar.
(2) *Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?* No
(3) *Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?*
(4) *What was the last action taken during the past legislative session?* It passed the Senate unanimously and languished on the House calendar.

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: **No other agencies impacted.**
Agency Contact (name, title, phone): **N/A**
Date Contacted: **N/A**

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments
N/A

Will there need to be further negotiation? ___ YES __x__ NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) **No fiscal impact.**
State **Sec. 1.** No fiscal impact. **Sec. 2.** CIGA obtains funds to pay covered claims from the receivership estate and from assessment of member insurers. To the extent member insurers are assessed, they may offset 100% of the assessment from premiums due the state over a period of five years, 20% each year, and they will repay premiums taxes if and when they receive a refund of assessments at or near the conclusion of the receivership. (1) The 30 day additional time period may result in increased cost to CIGA, although it would decrease CIGA's liability for unearned premium claims. Often, state insurance regulators stop an insurer from doing business many months before the insurer goes into liquidation, thus permitting an orderly transition of a book of business to other market participants prior to the liquidation and thereby avoiding replacement of insurance upon commencement of the liquidation proceedings. (2) Increasing the CIGA coverage cap to $500,000 will increase CIGA's claim liability by an unknown amount which will result in marginally higher assessments in the future subject to the right of premium tax offset and a possible future payment of additional premium taxes by member insurers who previously used the premium tax offset should they receive a refund or partial refund of CIGA assessments near the conclusion of the receivership. **Sec. 3.** CLHIGA obtains funds to pay covered claims from the receivership estate and from assessment of member insurers. To the extent member insurers are assessed, they may offset 100% of the assessment from premiums due the state over a period of five years, 20% each year, and they will repay premiums taxes if and when they receive a refund of assessments at or near the conclusion of the receivership. In the absence of this legislation, it is possible to interpret the CLHIGA Act to include CLHIGA liability for claims under Medicare Parts C and D. Because this legislation will expressly exclude from CLHIGA coverage for such claims, member insurers will not be assessed by CLHIGA to fund the claims, resulting in no premium tax offset with respect to such claims.
Federal No fiscal impact.
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Insert fully drafted bill here

Sec. 1. Subsection (6) of section 38a-838 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(6) "Insolvent insurer" means an insurer (A) (i) licensed to transact insurance in this state either at the time the policy was issued or when the insured event occurred, and (ii) against whom a final order of liquidation has been entered with a finding of insolvency [determined to be insolvent] by a court of competent jurisdiction in the insurer's state of domicile; (B) which is (i) the legal successor of an insurer that was licensed to transact insurance in this state either at the time the policy was issued or when the insured event occurred, by reason of a merger, provided such merger is approved by an insurance regulator having jurisdiction over such merger, and (ii) against whom a final order of liquidation has been entered with a finding of insolvency [determined to be insolvent] by a court of competent jurisdiction in the insurer's state of domicile; or (C) which (i) succeeds to the policy obligations of an insurer that was licensed to transact insurance in this state either at the time the policy was issued or when the insured event occurred, by reason of a division whereby policies issued by such licensed insurer are transferred to an insurer, and (ii) against whom a final order of liquidation has been entered with a finding of insolvency [is determined to be insolvent] by a court of competent jurisdiction in the insurer's state of domicile, provided such division is approved (I) in a jurisdiction that allows such division, and (II) by an insurance regulator having jurisdiction over such division. "Insolvent insurer" shall not be construed to mean any insurer with respect to which an order, decree, judgment or finding of insolvency, whether permanent or temporary in nature, or order of rehabilitation or conservation has been issued by a court of competent jurisdiction prior to October 1, 1971;

Sec. 2. Subsection (a) of section 38a-841 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) Said association shall: (1) Be obligated to the extent of the covered claims existing prior to the [determination of insolvency] order of liquidation and arising within [thirty] sixty days after [the determination of insolvency] such order, or before the policy expiration date if less than [thirty] sixty days after the [determination] order of liquidation, or before the insured replaces the policy or causes its cancellation, if he does so within [thirty] sixty days of such [determination] order, provided such obligation shall be limited as follows: (A) With respect to covered claims for unearned premiums, to one-half of the unearned premium on any policy, subject to a maximum of two thousand dollars per policy; (B) with respect to covered claims other than for unearned premiums, such obligation shall include only that amount of each such claim which is in excess of one hundred dollars and is less than three hundred thousand dollars for claims arising under policies of insurers determined to be insolvent prior to October 1, 2007, [and] four hundred thousand dollars for claims arising under policies of insurers determined to be insolvent on or after October 1, 2007 and prior to October 1, 2014, and five hundred thousand dollars for claims arising under policies of insurers placed into liquidation with a finding of insolvency on

or after October 1, 2014, except that said association shall pay the full amount of any such claim arising out of a workers' compensation policy, provided in no event shall said association be obligated (i) to any claimant in an amount in excess of the obligation of the insolvent insurer under the policy form or coverage from which the claim arises, or (ii) for any claim filed with the association after the expiration of two years from the date of the declaration of insolvency unless such claim arose out of a workers' compensation policy and was timely filed in accordance with section 31-294c; (2) be deemed the insurer to the extent of its obligations on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent; (3) allocate claims paid and expenses incurred among the three accounts, created by section 38a-839, separately, and assess member insurers separately (A) in respect of each such account for such amounts as shall be necessary to pay the obligations of said association under subdivision (1) of this subsection subsequent to an insolvency; (B) the expenses of handling covered claims subsequent to an insolvency; (C) the cost of examinations under section 38a-846; and (D) such other expenses as are authorized by sections 38a-836 to 38a-853, inclusive. The assessments of each member insurer shall be in the proportion that the net direct written premiums of such member insurer for the calendar year preceding the assessment on the kinds of insurance in such account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance in such account. Each member insurer shall be notified of its assessment not later than thirty days before it is due. No member insurer may be assessed in any year on any account an amount greater than two per cent of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in said account, provided if, at the time an assessment is levied on the all other insurance account, as defined in subdivision (3) of section 38a-839, the board of directors finds that at least fifty per cent of the total net direct written premiums of a member insurer and all its affiliates, for the year on which such assessment is based, were from policies issued or delivered in Connecticut, on risks located in this state, such member insurer shall be assessed only on such member insurer's net direct written premium that is attributable to the kind of insurance that gives rise to each covered claim. If the maximum assessment, together with the other assets of said association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available may be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. Said association may defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance provided that during the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when such payment will not reduce capital or surplus below the minimum amounts required for a certificate of authority. Such payments shall be refunded to those insurers receiving greater assessments because of such deferment or, at the election of the insurer, be credited against future assessments. Each member insurer serving as a servicing facility may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by such member insurer if they are chargeable to the account in respect of which

the assessment is made; (4) investigate claims brought against said association and adjust, compromise, settle, and pay covered claims to the extent of said association's obligations, and deny all other claims. The association shall pay claims in any order it deems reasonable including, but not limited to, payment in the order of receipt or by classification. It may review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which such settlements, releases and judgments may be properly contested; (5) notify such persons as the commissioner may direct under subdivision (1) of subsection (b) of section 38a-843; (6) handle claims through its employees or through one or more insurers or other persons designated by said association as servicing facilities, provided such designation of a servicing facility shall be subject to the approval of the commissioner, and may be declined by a member insurer; (7) reimburse each such servicing facility for obligations of said association paid by such facility and for expenses incurred by such facility while handling claims on behalf of said association and shall pay such other expenses of said association as are authorized by sections 38a-836 to 38a-853, inclusive.

Sec. 3. Subsection (f) of section 38a-860 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(f) (1) Sections 38a-858 to 38a-875, inclusive, shall provide coverage to the persons specified in subsections (a) to (d), inclusive, of this section for direct, nongroup life, health or annuity policies or contracts and supplemental contracts to such policies or contracts, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by said sections. Annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries and any immediate or deferred annuity contracts. (2) Said sections 38a-858 to 38a-875, inclusive, shall not provide coverage for: (A) Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract holder; (B) any policy or contract of reinsurance, unless assumption certificates have been issued; (C) any portion of a policy or contract to the extent that the rate of interest on which it is based or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value (i) averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, exceeds the rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, whichever is earlier; and (ii) on and after the date on which the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available; (D) a portion of a policy or contract issued to any plan or program of an employer, association or

similar entity to provide life, health or annuity benefits to its employees or members to the extent that such plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association or similar entity under (i) a multiple employer welfare arrangement as defined in Section 514 of the federal Employee Retirement Income Security Act of 1974, as amended from time to time; (ii) a minimum premium group insurance plan; or (iii) an administrative services only contract; (E) any stop-loss or excess loss insurance policy or contract providing for the indemnification of or payment to a policy owner, a contract owner, a plan or another person obligated to pay life, health or annuity benefits; (F) any portion of a policy or contract to the extent that it provides dividends, experience rating credits, voting rights or provides that any fees or allowances be paid to any person, including, but not limited to, the policy or contract holder, in connection with the service to or administration of such policy or contract; (G) any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state; (H) any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan; (I) any portion of an unallocated annuity contract that is not issued to, or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery; (J) any subscriber contract issued by a health care center; (K) a contractual agreement that establishes the insurer's obligation by reference to a portfolio of assets that is not owned or possessed by the insurance company; (L) an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including, but not limited to: (i) A claim based on marketing materials; (ii) a claim based on side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements; (iii) a misrepresentation of or regarding policy benefits; (iv) an extra-contractual claim; or (v) a claim for penalties or consequential or incidental damages; (M) a contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer; **[**and**]** (N) a portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subparagraph, the interest or change in value determined by using the procedures defined in the policy or contract shall be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and shall not be subject to forfeiture; and (O) any policy or contract providing hospital, medical, prescription drugs or other health care benefits pursuant to Part C or Part D of Subchapter XVIII of 42 USC 7, as amended from time to time, or any regulations issued thereunder.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID1101BailBonds.doc

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Insurance Department

Liaison: Jim Perras
Phone: 860.297.3864
E-mail: jim.perras@ct.gov

Lead agency division requesting this proposal:
Market Conduct

Agency Analyst/Drafter of Proposal: Attorney Antonio Caporale

Title of Proposal
An Act Concerning Surety Bail Bond Agents

Statutory Reference 38a-660

Proposal Summary
Sec. 1. Would change the date the "surety bail bond agent examination fund" is swept into the general fund from the end of the fiscal year to the end of the calendar year.

Sec. 2. Would require bail bond agents to take continuing education course as a requirement to maintain a bail bond agent's license

Sec. 3. . 3. Would cause a bail bond agent's license to automatically expire if the agent does not pay the **auditing annual assessment** on or before January 31

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? No
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Many other states have continuing education requirements
(3) Have certain constituencies called for this action? No
(4) What would happen if this was not enacted in law this session? Revocation of licenses would continue to be costly and time consuming. Funds established to audit agents would be prematurely sent to the general fund.

- **Origin of Proposal** ___ **New Proposal** _X__ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package? Section 1 was part of a larger bill.

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal? No.

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation? Rep. Flexer, Rep. Megna, Bail Bond Association

(4) What was the last action taken during the past legislative session? Section 1. was in SB 1093 which passed Senate 36 – o but was never taken up for a vote in the House

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

N/A

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) n/a

State
Funds swept early into the general fund in 2012 amounted to $30,000. The CID has become increasingly efficient at utilizing the funds in the short period it has to use them for its intended purpose of funding audits. Regardless of the enactment of this provision the funds that get swept into the general fund will continue to decrease.

Federal
n/a

Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

a. Amend 38a-660 to require bail bond agents to take continuing education courses in order to maintain their licenses with the Department. This proposal would be modeled on our current statutes that subject CT insurance producers to continuing education requirements to maintain licensure. Certainly, bail bond agents interact with a vulnerable population and continuing education should be perceived as good consumer protection legislation.

b. Allow for cancellation of bail bond agent license for failure to pay the assessment fee prior to the statutory due date. Currently, if an assessment fee goes unpaid the CID must go through a timely and costly administrative process in order to impose a sanction on a license or collect on the fee. This would streamline CID functions related to this matter and give us another tool in our mission to have a well regulated bail bond industry.

c. Amend 38a-660(9)(k)(3) and 38a-52a to change the sweep date of the assessment account from end of fiscal year to end of the calendar year to expand the period on which funds can be used by the CID for examinations from six months to a year. This would promote agency efficiency by allowing more of the money it collects to be used for its intended purpose rather than sending it to the general fund.

An Act Concerning Surety Bail Bond Agents

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

Section 1. Subsection (k) of Section 38a-660 of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof:

(k) (1) To further the enforcement of this section and sections 38a-660b to 38a-660m, inclusive, and to determine the eligibility of any licensee, the commissioner may, as often as the commissioner deems necessary, examine the books and records of any such licensee. Each person licensed as a surety bail bond agent in this state shall, on or before January thirty-first, annually, pay to the commissioner a fee of four hundred fifty dollars to cover the cost of examinations under this subsection.

(2) The fees received by the commissioner pursuant to subdivision (1) of this subsection shall be dedicated to conducting the examinations under said subdivision (1) and shall be deposited in the account established under subdivision (3) of this subsection.

(3) There is established an account to be known as the "surety bail bond agent examination account", which shall be a separate, nonlapsing account within the Insurance Fund established

under section 38a-52a. The account shall contain any moneys required by law to be deposited in the account and any such moneys remaining in the account at the [close of the fiscal] end of each calendar year shall be transferred to the General Fund.

(4) The license of any person licensed as a surety bail bond agent who fails to pay the fee specified in subdivision 1 of this subsection by its due date shall automatically expire on February first immediately following such due date.

Section 2. Subsection *l* of Section 38a-660 of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof:

(*l*) The commissioner may renew or continue a license upon payment of the appropriate fee, as specified in section 38a-11, without the resubmittal of the detailed information required in the original application, provided that the applicant has satisfied the continuing education requirements set forth in section 38a-660m, as amended by this Act.

Section 3. Section 38a-660m of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof:

The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of section 38a-660 and sections 38a-660b to 38a-660k, inclusive, and to establish continuing education requirements for persons licensed as surety bail bond agents, provided the commissioner shall suspend such requirements for any person who is a public official during the period such person serves as a public official, if the person is prohibited from selling insurance during that period. As used in this section, "public official" means any state-wide elected officer, any member or member-elect of the General Assembly, or a senator or representative in Congress.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID1101ThirdPartyAdministrator.doc

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Connecticut Insurance Department

Liaison: Jim Perras
Phone: 860.297.3864
E-mail: jim.perras@ct.gov

Lead agency division requesting this proposal:
Market Conduct

Agency Analyst/Drafter of Proposal:
Tim Lyons

Title of Proposal
An Act Concerning the Third Party Administrator Annual Report

Statutory Reference
38a-11, 38a-720l

Proposal Summary
Sec. 1: Combines annual report and renewal license fee together to total $450.00.
Sec. 2: Combines the annual report requirement with the license renewal application requirement

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) *Have there been changes in federal/state/local laws and regulations that make this legislation necessary?* **No**
(2) *Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?* **No**
(3) *Have certain constituencies called for this action?* **No**
(4) *What would happen if this was not enacted in law this session?* **The deadlines will remain the same and convenience to industry and efficiencies for the agency will not be realized.**

- **Origin of Proposal** **__x__ New Proposal** **___ Resubmission**

If this is a resubmission, please share:

(1) *What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?*
(2) *Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?*
(3) *Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?*
(4) *What was the last action taken during the past legislative session?*

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: **N/A** Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments **N/A**
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) NONE
State NONE
Federal NONE
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Sec. 1: Combines annual report and renewal license fee together to total $450.00. This eliminates the need for the industry to write two separate checks to the department, and for the department to process 2 separate checks at 2 different times Sec. 2: Provides that the annual report requirement is part of the renewal license application requirement. This will eliminate the need for industry to submit an annual report and license application separately and on different dates

An Act Concerning the Third Party Administrator Annual Report

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

Section 1. Section 38a-11 of the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2014):

Sec. 38a-11. (Formerly Sec. 38-50). Fees to be paid commissioner. (a) The commissioner shall demand and receive the following fees: (1) For the annual fee for each license issued to a domestic insurance company, two hundred dollars; (2) for receiving and filing annual reports of domestic insurance companies, fifty dollars; (3) for filing all documents prerequisite to the issuance of a license to an insurance company, two hundred twenty dollars, except that the fee for such filings by any health care center, as defined in section 38a-175, shall be one thousand three hundred fifty dollars; (4) for filing any additional paper required by law, thirty dollars; (5) for each certificate of valuation, organization, reciprocity or compliance, forty dollars; (6) for each certified copy of a license to a company, forty dollars; (7) for each certified copy of a report or certificate of condition of a company to be filed in any other state, forty dollars; (8) for amending a certificate of authority, two hundred dollars; (9) for each license issued to a rating organization, two hundred dollars. In addition, insurance companies shall pay any fees imposed under section 12-211; (10) a filing fee of fifty dollars for each initial application for a license made pursuant to section 38a-769; (11) with respect to insurance agents' appointments: (A) A filing fee of fifty dollars for each request for any agent appointment, except that no filing fee shall be payable for a request for agent appointment by an insurance company domiciled in a state or foreign country which does not require any filing fee for a request for agent appointment for a Connecticut insurance company; (B) a fee of one hundred dollars for each appointment issued to an agent of a domestic insurance company or for each appointment continued; and (C) a fee of eighty dollars for each appointment issued to an agent of any other insurance company or for each appointment continued, except that (i) no fee shall be payable for an appointment issued to an agent of an insurance company domiciled in a state or foreign country which does not require any fee for an appointment issued to an agent of a Connecticut insurance company, and (ii) the fee shall be twenty dollars for each appointment issued or continued to an agent of an insurance company domiciled in a state or foreign country with a premium tax rate below Connecticut's premium tax rate; (12) with respect to insurance producers: (A) An examination fee of fifteen dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of fifteen dollars to the commissioner for each examination taken by an applicant; (B) a fee of eighty dollars for each license issued; (C) a fee of eighty dollars per year, or any portion thereof, for each license renewed; and (D) a fee of eighty dollars for any license renewed under the transitional process established in section 38a-784; (13) with respect to public adjusters: (A) An examination fee of fifteen dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of fifteen dollars to the commissioner for each examination taken by an applicant; and (B) a fee of two hundred fifty dollars for each license issued or renewed; (14) with respect to casualty adjusters: (A) An examination fee of twenty dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of twenty dollars to the commissioner for each

examination taken by an applicant; (B) a fee of eighty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner two hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (15) with respect to motor vehicle physical damage appraisers: (A) An examination fee of eighty dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of eighty dollars to the commissioner for each examination taken by an applicant; (B) a fee of eighty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner two hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (16) with respect to certified insurance consultants: (A) An examination fee of twenty-six dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of twenty-six dollars to the commissioner for each examination taken by an applicant; (B) a fee of two hundred fifty dollars for each license issued; and (C) a fee of two hundred fifty dollars for each license renewed; (17) with respect to surplus lines brokers: (A) An examination fee of twenty dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of twenty dollars to the commissioner for each examination taken by an applicant; and (B) a fee of six hundred twenty-five dollars for each license issued or renewed; (18) with respect to fraternal agents, a fee of eighty dollars for each license issued or renewed; (19) a fee of twenty-six dollars for each license certificate requested, whether or not a license has been issued; (20) with respect to domestic and foreign benefit societies shall pay: (A) For service of process, fifty dollars for each person or insurer to be served; (B) for filing a certified copy of its charter or articles of association, fifteen dollars; (C) for filing the annual report, twenty dollars; and (D) for filing any additional paper required by law, fifteen dollars; (21) with respect to foreign benefit societies: (A) For each certificate of organization or compliance, fifteen dollars; (B) for each certified copy of permit, fifteen dollars; and (C) for each copy of a report or certificate of condition of a society to be filed in any other state, fifteen dollars; (22) with respect to reinsurance intermediaries, a fee of six hundred twenty-five dollars for each license issued or renewed; (23) with respect to life settlement providers: (A) A filing fee of twenty-six dollars for each initial application for a license made pursuant to section 38a-465a; and (B) a fee of forty dollars for each license issued or renewed; (24) with respect to life settlement brokers: (A) A filing fee of twenty-six dollars for each initial application for a license made pursuant to section 38a-465a; and (B) a fee of forty dollars for each license issued or renewed; (25) with respect to preferred provider networks, a fee of two thousand seven hundred fifty dollars for each license issued or renewed; (26) with respect to rental companies, as defined in section 38a-799, a fee of eighty dollars for each permit issued or renewed; (27) with respect to medical discount plan organizations licensed under section 38a-479rr, a fee of six hundred twenty-five dollars for each license issued or renewed; (28) with respect to pharmacy benefits managers, an application fee of one hundred dollars for each registration issued or renewed; (29) with respect to captive insurance companies, as defined in section 38a-91aa, a fee of three hundred seventy-five dollars for each license issued or renewed; (30) with respect to each duplicate license issued a fee of fifty dollars for each license issued; (31) with respect to surety bail bond agents, as defined in section 38a-660, (A) a filing fee of one

hundred fifty dollars for each initial application for a license, and (B) a fee of one hundred dollars for each license issued or renewed; and (32) with respect to third-party administrators, as defined in section 38a-720, (A) a fee of five hundred dollars for each license issued, and (B)[a fee of three hundred fifty dollars for each license renewed, and] a fee of four hundred and fifty dollars for each licensed renewed. [(C) a fee of one hundred dollars for each annual report filed pursuant to section 38a-720*l*.]

(b) If any state imposes fees upon domestic fraternal benefit societies greater than are fixed by this section or sections 38a-595 to 38a-626, inclusive, 38a-631 to 38a-640, inclusive, or 38a-800, the commissioner shall collect from each fraternal benefit society incorporated by or organized under the laws of such other state and admitted to transact business in this state, the same fees as are imposed upon similar domestic societies and organizations by such other state. The expense of any examination or inquiry made outside the state shall be borne by the society so examined.

(c) Each unauthorized insurer declared to be an eligible surplus lines insurer shall pay to the Insurance Commissioner, on or before May first of each year, an annual fee of one hundred twenty-six dollars in order to remain on the list of eligible surplus lines insurers.

(d) For service of process on the commissioner, the commissioner shall demand and receive a fee of fifty dollars for each person or insurer to be served. The commissioner shall also collect, for each hospital or ambulance lien filed, fifty dollars, and for each small claims notice filed, fifteen dollars, each of which shall be paid by the plaintiff at the time of service, the same to be recovered by him as part of the taxable costs if he prevails in the suit.

(e) Each insurance company depositing any security with the Treasurer pursuant to section 38a-83 shall pay to the commissioner three hundred fifteen dollars, annually. In case of an examination or appraisal made outside the office of the Treasurer, and in such case the company in whose behalf such examination or appraisal has been made shall pay to the commissioner two hundred dollars for such examination and the actual traveling expenses of the officer making such examination or appraisal.

Section 2. Section 38a-720*l* of the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2014):

Sec. 38a-720*l*. Annual report. (a) Each third-party administrator licensed under section 38a-720j shall file an annual report for the preceding calendar year with the commissioner on or before [July] October first of each year as part of its application for renewal of its license or within such extension of time as the commissioner may grant for good cause. The annual report shall be in the form and contain such information as the commissioner prescribes, including evidence that the surety bond required under subdivision (1) of subsection (a) of section 38a-720j and, if applicable, subsection (h) of section 38a-720j, remain in force. The information contained in such report shall be verified by at least two officers of the third-party administrator.

(b) The annual report shall include the complete names and addresses of all insurers or other persons with which the third-party administrator had written agreements during the preceding fiscal year.

[(c) At the time of filing the annual report, the third-party administrator shall pay a filing fee as specified in section 38a-11.

(d) The commissioner shall review the most recently filed annual report of each third-party administrator on or before September first of each year. Upon completion of its review, the commissioner shall: (1) Issue a certification to the third-party administrator that the annual report shows the third-party administrator is currently licensed and in good standing, or noting any deficiencies found in such annual report; or (2) update any electronic database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries, indicating that the annual report shows the third-party administrator is compliant with existing law, or noting any deficiencies found in such annual report.]