Agency Legislative Proposal - 2015 Session

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

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

State Agency:
Insurance Department

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Lead agency division requesting this proposal:
Financial Regulation

Agency Analyst/Drafter of Proposal:
Jon Arsenault/Beth Cook

Title of Proposal
AAC Financial Regulation of Insurers

Statutory Reference
38a-14; 38a-53; 38a-69a; 38a-85; 38a-129, 38a-130 38a-136, 38a-188; Sec. (h) of Public Act 14

Proposal Summary

Sec. 1. 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.2. Amend 38a-53 to provide the Commissioner discretion to extend the quarterly and annual financial statement filing deadline when the domiciliary regulator has waived such filings or approved filing delays in defined situations

Sec. 3 – Amend 38a-69a to align confidentiality provisions for financial analysis papers and materials to the financial examination confidentiality provisions (38a-14) and Holding Company (38a-137)

Sec. 4 – 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. 5. Amend 38a-129(b)(3) definition of "control" "controlled by" or "under common control with" with clarifying language concerning the Commissioner's authority to make a determination that control exists in fact nothwithstanding the absence of a presumption to that effect.

Sec. 6. – Amend 38a-130(a)(2)(A) concerning prior approval of agreements to acquire control of a domestic insurance company or corporation controlling a domestic insurer, by adding after the word "agreement" the words " "arrangement or understanding (written or oral)".

Sec. 7. Amend 38a-136(b)(1)(C)and (D) to mirror NAIC Holding Company Model for purposes of accreditation for 1/1/16.

Sec. 8 Amend 38a-188 to extend exam authority under the Holding company Act 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. 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. 2 Amend 38a-53 to provide the Commissioner discretion to extend the due date for filing quarterly and annual financial statements when the domiciliary regulator approved filing delays or the governor in the domiciliary state has declared a state of emergency and such state of emergency impairs the ability of the company or health care center to file the financial report or statement.

Sec. 3 - Sec. 3 – Amend 38a-69a to align confidentiality provisions for financial analysis papers and materials to the financial examination confidentiality provisions (38a-14) and Holding Company (38a-137)

Sec. 4 – 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. 5. Amend 38a-129(b)(3) to make express what is implied in the statutes, that the Commissioner may determine that a person exercises directly or indirectly either alone or pursuant to an agreement with one or more other persons such a controlling influence over the management and policies of an authorized insurer as to make it necessary or appropriate in the public interest or for the protection of the insurer's policyholders that the person be deemed to control the insurer, notwithstanding the absence of a presumption of control.

Sec. 6. Amend 38a-130(a)(2)(A) to clarify that an agreement , arrangement or understanding (written or oral) to a merge with or acquire control of, a domestic insurance company or any corporation controlling a domestic insurance company requires the filing of a Form A disclosure statement and the approval of the Insurance Commissioner.

Sec. 7 Amend 38a-136(b)(1)(C)and (D) to mirror NAIC Holding Company Model for purposes of accreditation for 1/1/16.

Sec. 8 Amend 38a-188 to extend exam authority under the Holding Company Act to health care centers

- **Origin of Proposal ___ New Proposal _x__ Resubmission (for some parts)**

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?**did not get out of committee***

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
Federal n/a
Additional notes on fiscal impact

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

AN ACT CONCERNING FINANCIAL REGULATORY OVERSIGHT OF INSURANCE COMPANIES.

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

Sec. 1. Subsection (e) of section 38a-14 of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof :

(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 entity examined, together with a notice that shall afford the 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 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 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. 2. Subsection (e) of section 38a-53 of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof :

(e) Any insurance company or health care center doing business in this state that fails to file any report or statement required under this section shall pay a late filing fee of one hundred seventy-five dollars per day for each day from the due date of such report or statement to the date of filing. The commissioner may extend the filing period if (1) the insurance company or health care center cannot file such report or statement because the governor of such company's or center's state of domicile has proclaimed a state of emergency in such state and such state of emergency impairs the company's or center's ability to file the report or statement, or (2) the insurance regulatory official of the state of domicile of a foreign insurance company has permitted such company, or the commissioner has permitted a domestic insurance company or health care center, to file such report or statement late.

Sec. 3. Subsection (a) of section 38a-69a of the general statutes is repealed and the following is substituted in lieu thereof:

(a) All financial analyses, financial examination workpapers, operating and financial condition reports concerning any insurance company, fraternal benefit society or health care center prepared by or on behalf of or for the use of the Insurance Commissioner or the Insurance Department examiner, shall be [confidential unless such documents are otherwise a matter of public record, or the commissioner, in the commissioner's opinion deems it in the public interest to disclose or otherwise make available for public inspection the information contained in such documents] 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 (c) of this section. Access to such information may be granted by the commissioner to the National Association of Insurance Commissioners so long as it agrees, in writing, to hold it confidential.

(b) Any supplemental compensation exhibit or stockholder information supplement in an annual report filed with the commissioner and prepared in accordance with the National Association of Insurance Commissioners Annual Statement Instructions shall be confidential and shall not be available for public inspection if submitted by a nonprofit insurance company that has fewer than one hundred fifty employees. The provisions of this subsection shall not apply to information in such exhibit or supplement concerning such company's three most highly compensated officers.

(c) Nothing contained in this section shall prevent or be construed as prohibiting the commissioner from disclosing the content of any financial analyses, financial examination workpapers, operating and financial condition reports examination report, preliminary examination report or results, or any matter relating thereto, to the Insurance Department of this or any other state or country, or to law enforcement officials of this or any other state or to any agency of the federal government at any time, so long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential.

Sec. 4. Subparagraph (A) of 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) (I) The insurance regulatory official with principal oversight of the trust may authorize a reduction in the required trusteed surplus.

[(ii)**]** (II) For a trust over which the commissioner has principal regulatory oversight, 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 may authorize a reduction in the required trusteed surplus. Such reduction shall be made only after the 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.

Sec. 5. Subdivision (3) of subsection (b) of section 38a-129 of the general statutes is repealed and the following is substituted in lieu thereof:

(3) “Control”, “controlled by” or “under common control with” has the same meaning as provided in section 38a-1. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten per cent or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard that a person exercises directly or indirectly either alone or pursuant to an agreement, arrangement or understanding (written or oral) with one or more other persons such a controlling influence over the management or policies of an authorized insurer as to make it necessary or appropriate in the public interest or for the protection of the insurer’s policyholders that the person be deemed to control the insurer. The commissioner shall make [and making] specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect;

Sec. 6. Subparagraph (A) of subdivision (2) of subsection (a) of section 38a-130 of the general statutes is repealed and the following is substituted in lieu thereof:

(2) (A) (i) No person shall enter into an agreement, arrangement or understanding (written or oral) to merge with or otherwise acquire control of a domestic insurance company or any corporation controlling a domestic insurance company unless, at the time any form of initial offer, request or invitation is made or the agreement, arrangement or understanding is entered into, or prior to the acquisition of such securities or proxies if no offer, agreement, arrangement or understanding is involved, such person has filed with the commissioner and has sent to such insurance company a statement containing the information required by subsection (b) of this section and such offer, request, invitation, agreement, arrangement, understanding or acquisition has been approved by the commissioner in the manner hereinafter prescribed.

(ii) If any offer, request, invitation, agreement or acquisition is proposed to be made by means of a registration statement under the Securities Act of 1933 or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934, the person required to file the statement under subparagraph (A)(i) of this subdivision may utilize the registration statement or such documents furnishing the

similar information to provide the information required by subsection (b) of this section, to the extent that the registration statement or such documents contains such information.

Sec. 7. Subsection (b) of section 38a-136 of the general statutes is repealed and the following is substituted in lieu thereof :

(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 projected change in the insurance company'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. 8. Subsection (a) of section 38a-188 of the general statutes is repealed and the following is substituted in lieu thereof:

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, 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, 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.

Agency Legislative Proposal - 2015 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.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 Insurers Rehabilitation and Liquidation Act.

Statutory Reference: Chapter 704c.

Proposal Summary

Sec. 1 amends the Connecticut insurance receivership statutes to add provisions concerning the rehabilitation or liquidation of a domestic insurance company that is a covered financial company under the federal Dodd-Frank Wall Street Reform and Consumer Protection Act. Such provisions: set forth the grounds upon which the Insurance Commissioner may file a petition for an order of rehabilitation or liquidation pursuant to the provisions of Chapter 704c concerning the grounds for rehabilitation and liquidation; provides that after notice to the insurer, the Superior Court may grant an order on the petition for rehabilitation or liquidation within 24 hours after its filing and that if the court does not make a determination on a petition for rehabilitation or liquidation filed by the Commissioner within 24 hours after its filing, then it shall be deemed granted by operation of law upon the expiration of the 24-hour period; set forth provisions concerning the court order and the Commissioner's powers and authority.

Sec. 2 amends Conn. Gen. Stat. § 38a-930, concerning voidable property transfers made within one year of receivership of an insurer, to exempt reinsurance commutations of the insurer that were approved by the Insurance Commissioner pursuant to the administrative supervision statute, Conn. Gen. Stat. § 38a-962d.

Sec. 3 amends Conn. Gen. Stat. § 38a-944a, concerning receivership treatment of netting agreements and qualified financial contracts (QFC), to provide for a 24 hour stay with respect to the termination of a netting agreement or QFC of an insurer placed in an insolvency proceeding.

Sec. 4 amends Conn. Gen. Stat. § 38a-140(b), concerning impairment of the financial condition of a domestic insurer due to a violation of the Insurance Holding Company Act, to make a technical change due to the repeal of Conn. Gen. Stat. § 38a-18 in Section 5.

Sec. 5 repeals Conn. Gen. Stat. § 38a-18 concerning grounds for the Insurance Commissioner to make application to the Superior Court for an order placing any domestic insurance company into receivership.

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

PROPOSAL BACKGROUND

Reason for Proposal: Sec. 1. Title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203 (the "Dodd-Frank Act") creates a new orderly liquidation authority for the dissolution of failing systemically important financial companies, including qualifying insurance companies when certain conditions are found to exist, with the Federal Deposit Insurance Corporation (FDIC) generally seeking the appointment as receiver. However, in the case of qualifying insurance companies, the liquidation or rehabilitation of such a financial company will be conducted as provided under state law, however the Insurance Commissioner's responsibilities under the Dodd-Frank Act require state statutes that assure immediate execution of state receiverships necessary to effectively respond to a national financial crisis. If there is a federal determination that a domestic insurance company meets the standards in 12 U.S.C. § 5383(b), then the Dodd-Frank Act anticipates that the insurance company would be placed immediately into receivership pursuant to state law. If at the end of the 60-day period provided for under 12 U.S.C. § 5383(e)(3) the Insurance Commissioner has not filed the appropriate state judicial action to place the insurer into orderly liquidation, the FDIC shall have the authority to stand in the place of the Commissioner and file the appropriate judicial action in the appropriate state court to place the insurer into orderly liquidation under the laws and requirements of the state. The text of this legislative proposal was developed by the National Association of Insurance Commissioners as a guide to states for establishing timing and procedural rules for the expeditious entry and implementation of receivership orders that involve resolution under the Dodd-Frank Act of systemically important insurance financial institutions.

Sec. 2. The Insurance Commissioner has statutory authority to place a domestic insurer that is in a hazardous financial condition under the administrative supervision of the Commissioner to supervise the operations of the insurer, pre-receivership. In supervision, the insurer's management remains in place subject to restrictions in the supervision order (based on Conn. Gen. Stat. § 38a-962d) and the direction of the Commissioner as supervisor. With the approval of the Commissioner, an insurer under administrative supervision may negotiate and enter into a commutation of one or more reinsurance agreements made with another insurer. Such commutation(s) eliminate all present and future obligations between the parties arising under the reinsurance agreement in exchange for current consideration, and usually will have the effect of improving the financial condition of the company under supervision. In the event the insurer goes into receivership, however, Conn. Gen. Stat. § 38a-930 gives the Commissioner as the court appointed liquidator of the insurer, the ability to void the transfer of money paid by the insurer in liquidation to its counterparty in the reinsurance commutation if the transfer was made within one year of the date of liquidation. This legislation will protect reinsurance commutations made within one year of liquidation when the commutation was approved by the Commissioner because the insurer was prior to liquidation, under the administrative supervision of the Commissioner. This will benefit both parties to the transaction because it will help facilitate

commercially reasonable commutations involving a financially impaired insurer to help eliminate the financial impairment or otherwise resolve its liabilities as well as allow the counter-party to obtain the benefit of the negotiated agreement that was approved by the Commissioner in the event the insurer subsequently goes into liquidation proceedings.

Sec. 3. Conn. Gen. Stat. § 38a-944a is an insurance receivership statute that permits the exercise of a contractual right to cause the termination, liquidation, acceleration or close out of obligations with respect to any netting agreement or qualified financial contract (QFC) with an insurer because of the insolvency, financial condition or default of the insurer, or the commencement of a receivership proceeding. QFC is defined as a commodity contract, forward contract, repurchase agreement, securities contract, swap agreement and similar agreements. The statute is based upon similar provisions contained in the U.S. Bankruptcy Code and the Federal Deposit Insurance Act (FDIA). The proposed amendment will adopt a similar provision that exists in the FDIA to provide for a 24 hour stay to allow for the transfer of a QFCs by the receiver of the insurer to another entity rather than permitting the immediate termination and netting of the QFC.

Sec. 4. Conn. Gen. Stat. § 38a-140(b), must be amended to replace the reference to Conn. Gen. Stat. § 38a-18 (which is repealed by Section 5 of this bill) with a general reference to the chapter governing insurance receivership proceedings.

Sec. 5. Conn. Gen. Stat. § 38a-18 (formerly Conn. Gen. Stat. § 38-9 and deriving from 1902 legislation), should have been repealed in 1979 when Public Act 79-383 enacted the Insurers Rehabilitation and Liquidation Act , now codified as Chapter 704c, and all of the then existing insurance receivership statutes other than this section were repealed by P.A. 79-383 § 60. The provisions of Chapter 704c provide a comprehensive scheme for the rehabilitation and liquidation of insurance companies. Conn. Gen. Stat. § 38a-18 serves no purpose and should be repealed.

Please consider the following, if applicable:

(1) *Have there been changes in federal/state/local laws and regulations that make this legislation necessary? Yes.*

(2) *Has this proposal or something similar been implemented in other states?* Yes. *If yes, what is the outcome(s)?* Better preparedness for implementation of receivership orders under Dodd-Frank Act resolution of systemically important insurers.

(3) *Have certain constituencies called for this action?* Yes. The NAIC issued a guideline to state Insurance Commissioners with respect to Dodd-Frank Act receivership implementation.

(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:

(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.**

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

Insert fully drafted bill here

AN ACT CONCERNING THE INSURERS REHABILITATION AND LIQUIDATION ACT.

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

Section 1. (NEW) (*Effective October 1, 2015*) **Grounds for and provisions applicable to rehabilitation or liquidation of a domestic insurer that is a covered financial company under the federal Dodd-Frank Wall Street Reform and Consumer Protection Act.**

(a) The provisions of this section apply in accordance with Title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203 with respect to an insurance company that is a covered financial company, as that term is defined under 12 U.S.C. § 5381.

(b) The Commissioner may petition the Superior Court for an order of rehabilitation or liquidation of a domestic insurer pursuant to this section on any of the following grounds:

(1) Upon a determination and notification given by the Secretary of Treasury, in consultation with the President of the United States, that the insurer is a financial company satisfying the requirements of 12 U.S.C. § 5383(b), and the board of directors, or a body performing similar functions, of the insurer acquiesces or consents to the appointment of a receiver pursuant to

12 U.S.C. § 5382(a)(1)(A)(i), with such consent to be considered as consent to an order of rehabilitation or liquidation; or

(2) Upon an order of the United States District Court for the District of Columbia under 12 U.S.C. § 5382(a)(1)(A)(iv)(I) granting the petition of the Secretary of the Treasury concerning the insurer under 12 U.S.C. § 5382(a)(1)(A)(i); or

(3) A petition by the Secretary of the Treasury of the United States concerning the insurer is granted by operation of law under 12 U.S.C. § 5382(a)(1)(A)(v).

(c) Notwithstanding any other provision in this Act or other law, after notice to the insurer, the receivership court may grant an order of rehabilitation or liquidation within twenty-four hours after the filing of such a petition pursuant to this section.

(d) If the Superior Court does not make a determination on the petition for rehabilitation or liquidation filed pursuant to this section within twenty-four hours after the filing of the petition, it shall be deemed granted by operation of law upon the expiration of the twenty-four hour period. At the time that an order is deemed granted under this section, the provisions of Chapter 704c shall be deemed to be in effect, and the Commissioner shall be deemed to be appointed as receiver and have all of the applicable powers provided by Chapter 704c, regardless of whether an order has been entered by the Superior Court. If an order is deemed granted by operation of law under this subsection, the Superior Court shall expeditiously enter an order of rehabilitation or liquidation that:

(1) is effective as of the date that it is deemed granted by operation of law; and

(2) conforms to the provisions for rehabilitation or liquidation contained in Chapter 704c, as applicable.

(e) Any order of rehabilitation or liquidation made pursuant to this section shall not be subject to any stay or injunction pending appeal.

(f) Nothing in this section shall be construed to supersede or impair any other power or authority of the Commissioner or the Superior Court under this Act.

Sec. 2. Section 38a-930 of the general statutes is amended by adding subsection (l) as follows:

(NEW) (*Effective October 1, 2015*) (l) Notwithstanding the provisions of subsection (a) of this section, a transfer pursuant to a commutation of a reinsurance agreement approved by the Commissioner pursuant to section 38a-962d, shall not be voidable as a preference. For purposes of this subsection, a commutation of a reinsurance agreement is the elimination of all present and future obligations between the parties, arising from the reinsurance agreement, in exchange for a current consideration.

Sec. 3. Subsection (a) of section 38a-944a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015)*:

(a) **(1)** Notwithstanding any provision of sections 38a-903 to 38a-961, inclusive, including any provision permitting the modification of contracts, or other law of a state, and subject to the provisions of subdivision (2) of this subsection, no person shall be stayed or prohibited from exercising: **[**(1)**]** **(A)** A contractual right to terminate, liquidate or close out any netting agreement or qualified financial contract with an insurer because of: **[**(A)**]** **(i)** The insolvency, financial condition or default of the insurer at any time, provided that the right is enforceable under applicable law other than sections 38a-903 to 38a-961, inclusive, or **[**(B)**]** **(ii)** the commencement of a formal delinquency proceeding under sections 38a-903 to 38a-961, inclusive. **[**(2)**]** **(B)** Any right under a pledge, security, collateral or guarantee agreement or any other similar security arrangement or credit support document relating to a netting agreement or qualified financial contract. **[**(3)**]** **(C)** Subject to any provision of subsection (b) of section 38a-932, any right to set off or net out any termination value, payment amount, or other transfer obligation arising under or in connection with a netting agreement or qualified financial contract where the counterparty or its guarantor is organized under the laws of the United States or a state or foreign jurisdiction approved by the Securities Valuation Office of the National Association of Insurance Commissioners as eligible for netting.

(2) A person who is a party to a netting agreement or qualified financial contract under this section with an insurer that is the subject of an insolvency proceeding may not exercise any right that the person has to terminate, liquidate, accelerate or close out the obligations with respect to the contract by reason of the insolvency, financial condition or default of the insurer, or by the commencement of a formal delinquency proceeding, (A) until 5:00 p.m. Eastern time on the business day following the date of appointment of a receiver; or (B) after the person has received notice that the contract has been transferred pursuant to the provisions of this section.

Sec. 4. Subsection (b) of section 38a-140 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015)*:

(b) Whenever it appears to the commissioner that any person has committed a violation of sections 38a-129 to 38a-l40, inclusive, that so impairs the financial condition of a domestic insurance company as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, securityholders or the public, the commissioner may proceed as provided in [section 38a-18] chapter 704c to take possession of the property of such domestic insurance company and to conduct the business thereof.

Sec. 5. Section 38a-18 of the general statutes is repealed. (*Effective October 1, 2015*)

JEA October 21, 2014

Agency Legislative Proposal - 2013 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): CID1001DishonoredPayments.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: Licensing Unit

Agency Analyst/Drafter of Proposal:
Antonio Caporale

Title of Proposal
An Act Concerning Dishonored Payments Issued to the Insurance Commissioner

Statutory Reference C.G.S. sec. 38a-712

Proposal Summary
The proposal amends subsection (b) of section 38a-712 by allowing the Commissioner to suspend the license of a producer if such producer submits any form of payment that is subsequently dishonored to the Commissioner. Currently, the Commissioner has the authority to suspend the license of a producer if such producer submits a check that is subsequently dishonored.

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 Commissioner would have to follow the longer process outlined in the UAPA to suspend the license of a producer who submits a payment other than by check that is subsequently dishonored.

- **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: None
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

There will be a negligible saving of resources currently employed to collect dishonored payments.

Federal

None

Additional notes on fiscal impact

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

Insert fully drafted bill here

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

Section 1. Subsection (b) of section 38a-712 is repealed and the following is substituted in lieu thereof:

(b) If, upon investigation of a report concerning a failure to remit premiums, the commissioner determines that a producer has received premiums directly or indirectly from insureds and has failed to remit them to the proper company, its state agent or managing general agent, he may, following a hearing as specified in section 38a-774, suspend or revoke the license of the producer. Upon receipt of a report concerning a dishonored check or upon dishonor of a check or other form of payment issued by a producer to the Insurance Department of the state of Connecticut, the commissioner shall notify the producer issuing such check or other form of payment of the report. If an arrangement for payment of such funds is not made to the satisfaction of the commissioner by the producer within fifteen days of receipt of such notice, the license of the producer shall be automatically suspended. Within sixty days of receipt of such notice the producer may make written demand upon the commissioner for a hearing to show cause why the suspension should be terminated. Such hearing shall be held within thirty days from the date of receipt of the written demand. If by the end of the sixty-day demand period no hearing has been demanded, the license of the producer shall be revoked. The commissioner may institute procedures for the restoration of the licensee's insurance accounts to best protect the interests of all parties concerned.

Agency Legislative Proposal - 2013 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): CID1001PortableElectronics.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: Licensing Unit

Agency Analyst/Drafter of Proposal:
Antonio Caporale

Title of Proposal
An Act Concerning the Licensing of Portable Electronic Devices

Statutory Reference Public Act 14-64

Proposal Summary
The proposal amends subsection (b) of section 1 of Public Act 14-64 by providing that any license issued by the Commissioner to a seller of portable electronics insurance shall remain in effect until January 31 of even-numbered years

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? Licenses issued to sellers of portable electronics insurance would expire two years from the date of issuance.

- **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: None 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

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

Streamlines the expiration of licenses for administrative efficiencies.

Insert fully drafted bill here

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

Subsection (b) of Public Act 14-64 is repealed and the following is replaced in lieu thereof:

(b) (1)(A) No seller shall offer or sell portable electronics insurance in this state without obtaining a portable electronics insurance license from the Insurance Commissioner as set forth in this subsection, except that a seller offering or selling portable electronics insurance in this state prior to October 1, 2014, may continue to offer or sell such insurance while the application from the Insurance Commissioner is pending and during the application process. Such license shall authorize any employee or authorized representative of such seller to offer or sell portable electronics insurance at each location where the seller engages in portable electronics transactions.

(B) Any such license issued by the commissioner shall be in force until the thirty-first day of January in each even-numbered year unless sooner revoked or suspended.

(2) No such employee or authorized representative shall be required to be licensed under chapter 701a of the general statutes, provided:

(A) The seller obtains and maintains such portable electronics insurance license;

(B) The insurer issuing a portable electronics insurance policy to the seller or a supervising entity of such insurer supervises the administration of the seller's portable electronics insurance program; and

(C) No such employee or authorized representative holds himself or herself out as a licensed insurance producer.

(3) (A) (i) Any seller seeking to obtain a portable electronics insurance license shall submit an initial sworn application to the Insurance Department on a form prescribed by the Insurance Commissioner. Such application shall include (I) the name, residence address and other information as said commissioner may require for an employee or an officer of the seller that is designated by such seller as the individual responsible for the seller's compliance with this section. If the seller derives more than fifty per cent of its revenue from the sale of portable electronics insurance, the seller shall include the name, residence address and other information as said commissioner may require of all the seller's shareholders who are directly or indirectly the beneficial owner of ten per cent or more of any class of security of such seller, and of all its officers and directors, and (II) the address of the applicant's home office. Such application shall be

accompanied by the fees set forth in section 38a-11 of the general statutes, as amended by this act. Each portable electronics insurance license shall be valid for two years.

(ii) Any seller seeking to renew a portable electronics insurance license shall submit to the Insurance Department any changes to the initial application and any other information the Insurance Commissioner may require and the renewal fee set forth in section 38a-11 of the general statutes, as amended by this act.

(B) Any seller offering or selling portable electronics insurance in this state prior to October 1, 2014, shall apply for a portable electronics insurance license not later than ninety days after the Insurance Commissioner makes the application for such license available. On and after October 1, 2014, a seller seeking to offer or sell portable electronics insurance in this state shall obtain such license prior to offering or selling such insurance in this state.

Agency Legislative Proposal - 2015 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): CID1001TPAReports.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/Fraud Investigation

Agency Analyst/Drafter of Proposal: Kurt Swan/Beth Cook
111314

Title of Proposal
AAC Third Party Administrator Annual Reports

Statutory Reference
38a-11; 38a-720*l*

Proposal Summary
Amend the TPA statute by eliminating the separate annual reporting requirement with a $100 fee found in 38a-11(32). Content of the annual report will be incorporated into Annual License Renewal Application. The $100 annual report fee and the $350 license renewal fee will be combined to equal one $450 fee. There will be no revenue gain or loss to the state, there will simply be administrative efficiencies for the state and a less burdensome regulatory process for the TPAs.

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
(3) Have certain constituencies called for this action? internal resources
(4) What would happen if this was not enacted in law this session? continue as is

- **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?
(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?

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)
n/a

State
Revenue neutral

Federal

n/a

Additional notes on fiscal impact

The annual report requirement will be incorporated into the annual license renewal application requirement and the two fees will be combined to create administrative efficiencies. There is no loss or gain of revenue for the State.

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

Currently, there is an annual report due for each licensed TPA pursuant to 38a-720*l*. This is due in July and requires them to submit certain information along with a fee, prior to the renewal of their license in October. The proposal suggests that we require that all information be submitted at the time of renewal. Currently, the process creates additional and unnecessary steps and is confusing to the TPA companies, which do not always understand that the renewal and annual report are 2 separate issues. The current annual report process is duplicative and inefficient. This proposal would eliminate the annual report as a separate requirement and add the annual report information into the license renewal process and add the fees together. The outcome will be a better use of Department resources and less confusing to licensees.

Insert fully drafted bill here

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

Sec. 1. Section 38a-11(32) of the general statues is repealed and the following is substituted in lieu thereof:

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] four hundred and fifty dollars for each license renewed[, and (C) a fee of one hundred dollars for each annual report filed pursuant to section 38a-720*l]*.

Sec. 2. Section 38a-*720l* of the general statues is repealed and the following is substituted in lieu thereof:

(a) Each third-party administrator [licensed] seeking to renew the license issued under section 38a-720j shall [file] include with the renewal filing [on or before July first of each year 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 provided shall be verified by at least two officers of the third-party administrator.

(b) The [annual report]filing 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.]

Agency Legislative Proposal - 2015 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): CID1214BailBonds.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:
Fraud and Investigations

Agency Analyst/Drafter of Proposal:
Antonio Caporale

Title of Proposal
An Act Concerning Changes to the Bail Bond Statutes

Statutory Reference 38a-660 *et seq.*

Proposal Summary
Amend subsection (k) of section 38a-660 to provide (1) that the Department can cancel the surety bail bond license of any person that fails to pay the annual $450.00 assessment fee by the due date; and (2) change, from fiscal year to calendar year, the date on which the funds remaining in the account that holds the assessment fee are swept into the General Fund.

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? No impact.

- **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? Opposition by a bail bond agency
(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? Bail bond industry
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

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

Agency Name: None 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 Revenue neutral
Federal None
Additional notes on fiscal impact

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

None

Insert fully drafted bill here

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

Section 1. Subsection (k) of section 38a-660 of the general statutes is repealed and the following is substituted in lieu thereof :

(k) (1) (A) To further the enforcement of this section and sections 38a-660b to 38a-660m, inclusive, as amended by this act, 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.

(B) If such person fails to pay such fee on or before January thirty-first, annually, the license of such person shall automatically expire on the February first immediately following. The commissioner shall timely notify, annually, each person licensed as a surety bail bond agent in this state about such automatic expiration provision.

(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.

Agency Legislative Proposal - 2015 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): CID1214GroupwideSupervision.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, 129, 38a-135, 38a-137.

Proposal Summary

To amend the Insurance Holding Company System Regulatory Act, to authorize the Insurance Commissioner to serve as group-wide supervisor for any internationally active insurance group that has an insurer registered pursuant to Conn. Gen. Stat. § 38a-135. As group-wide supervisor, the Commissioner is authorized to: access the enterprise risks with the group; request information necessary and appropriate for such assessment; coordinate and through the authority of the regulator officials of the jurisdictions where members of the insurance group are domiciled 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 state, federal and international regulatory agencies for members within the internationally active insurance 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 agencies for members of the group providing the basis for or otherwise clarifying the Commissioner's role as group-wide supervisor, including provisions for resolving disputes with other regulatory authorities; and other group-wide supervision activities as considered necessary by the Commissioner.

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 (IHCS) that is an "internationally active insurance group", defined as having premiums written in at least three countries which is at least 10% of the IHCS's total gross written premiums and the total assets of the IHCS are at least $50 billion or the total gross written premiums of the IHCS are at least $10 billion. 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 of internationally active insurance groups.**

(3) *Have certain constituencies called for this action?* **NAIC members and insurance industry groups.**

(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** **__ New Proposal** **_X_ Resubmission (same topic, revised language)**

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 2014 SB 196 (File 318) passed the Senate late in session and died on House calendar.**

(2) *Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?* **Yes. This proposal adopts NAIC model legislation which reflects the input of the insurance industry by the NAIC in the drafting process.**

(3) *Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?* **Insurance Department, IAC, ACLI.**

(4) *What was the last action taken during the past legislative session?* **See (1) above.**

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 Group-wide Supervision for Internationally Active Insurance Groups

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

Section 1. Subsection (b) of section 38a-129 of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2015)*:

(b) As used in sections 38a-129 to 38a-140, inclusive, the following terms shall have the respective meanings hereinafter set forth, unless the context shall otherwise require:

(1) "Affiliate" or "affiliated" has the same meaning as provided in section 38a-1;

(2) "Commissioner" means the Insurance Commissioner and any assistant to the Insurance Commissioner designated and authorized by the commissioner while acting under such designation;

(3) "Control", "controlled by" or "under common control with" has the same meaning as provided in section 38a-1. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten per cent or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect;

(4) "Enterprise risk" means any activity, circumstance, event or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or the insurer's insurance holding company system as a whole, including, but not limited to, any activity, circumstance, event or series of events that would cause an insurer's risk-based capital to fall below minimum threshold levels, as described in subsection (d) of section 38a-72 or, for a health care center, in

subdivision (2) of subsection (a) of section 38a-193, or would cause the insurer to be in a hazardous financial condition;

(5) "Group-wide supervisor" means the regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is determined or acknowledged by the commissioner under subsection (o) of section 38a-135, as amended by section 2 of this act, to have sufficient significant contacts with the internationally active insurance group.

[(5)] (6) "Insurance holding company system" means two or more affiliated persons, one or more of which is an insurance company;

[(6)] (7) "Insurance company" or "insurer" has the same meaning as provided in section 38a-1, except that it does 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;

(8) "Internationally active insurance group" means an insurance holding company system that (A) includes an insurer registered under section 38a-135; and (B) meets the following criteria: (i) premiums written in at least three countries, (ii) the percentage of gross premiums written outside the United States is at least ten percent of the insurance holding company system's total gross written premiums, and (iii) based on a three-year rolling average, the total assets of the insurance holding company system are at least fifty billion dollars or the total gross written premiums of the insurance holding company system are at least ten billion dollars.

[(7)] (9) "NAIC" means the National Association of Insurance Commissioners;

[(8)] (10) "Person" has the same meaning as provided in section 38a-1, or any combination of persons so defined acting in concert;

[(9)] (11) A "securityholder" of a specified person means one who owns any security of such person, including common stock, preferred stock, debt obligations and any other security convertible into or evidencing the right to acquire any of the foregoing;

[(10)] (12) "Subsidiary" has the same meaning as provided in section 38a-1;

[(11)] (13) "Voting security" includes any security convertible into or evidencing a right to acquire a voting security.

Sec. 2. Section 38a-135 of the general statutes is amended by adding subsection (o) as follows *(Effective October 1, 2015)*:

(NEW) (o) Group-wide Supervision of Internationally Active Insurance Groups. (1) The commissioner is authorized to act as the group-wide supervisor for any internationally active insurance group in accordance with the provisions of this section. However, the commissioner may otherwise acknowledge another regulatory official as the group-wide supervisor where the internationally active insurance group:

(A) Does not have substantial insurance operations in the United States;

(B) Has substantial insurance operations in the United States, but not in this state; or

(C) Has substantial insurance operations in the United States and this state, but the Commissioner has determined pursuant to the factors set forth in subdivisions (2) and (6) of this subsection that the other regulatory official is the appropriate group-wide supervisor.

An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the commissioner make a determination or acknowledgment as to a group-wide supervisor pursuant to this subsection.

(2) In cooperation with other state, federal and international regulatory agencies, the commissioner will identify a single group-wide supervisor for an internationally active insurance group. The commissioner may determine that the commissioner is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in this state. However, the commissioner may acknowledge that another regulatory official from another jurisdiction is the appropriate group-wide supervisor for the internationally active insurance group. The commissioner shall consider the following factors when making a determination or acknowledgment under this subsection:

(A) The place of domicile of the insurers within the internationally active insurance group that hold the largest share of the group's premiums, assets or liabilities,

(B) The place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group;

(C) The location of the executive offices or largest operational offices of the internationally active insurance group;

(D) Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the commissioner determines to be:

a. Substantially similar to the system of regulation provided under the laws of this state, or

b. Otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials;

(E) Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the commissioner with reasonably reciprocal recognition and cooperation.

However, a commissioner identified under this subsection as the group-wide supervisor may determine that it is appropriate to acknowledge another supervisor to serve as the group-wide supervisor. The acknowledgment of the group-wide supervisor shall be made after consideration of the factors listed in paragraphs (A) through (E), inclusive, of this subdivision, and shall be made in cooperation with and subject to the acknowledgment of other regulatory officials involved with supervision of members of the internationally active insurance group, and in consultation with the internationally active insurance group.

(3) Notwithstanding any other provision of law, when another regulatory official is acting as the group-wide supervisor of an internationally active insurance group, the commissioner shall acknowledge that regulatory official as the group-wide supervisor. However, in the event of material change in the internationally active insurance group that results in: (A) the internationally active insurance group's insurers domiciled in this state holding the largest share of the group's premiums, assets or liabilities; or (B) this state being the place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group, the commissioner shall make a determination or acknowledgment as to the appropriate group-wide supervisor pursuant to Subdivision (2).

(4) 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 may act as the group-wide supervisor of an internationally active insurance group or if the commissioner may acknowledge another regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision by the commissioner, the commissioner shall notify the insurer registered pursuant to this section and the ultimate controlling person with the

internationally active insurance group. The internationally active insurance group shall have not less than thirty days to provide the commissioner with additional information pertinent to the pending determination. The commissioner shall publish in the Connecticut Law Journal and on the Insurance Department internet website the identity of internationally active insurance groups that the commissioner has determined are subject to group-wide supervision by the commissioner.

(5) If the commissioner is the group-wide supervisor for an internationally active insurance group, the commissioner is authorized to engage in any of the following group-wide supervision activities:

(A) Assess the enterprise risks within the internationally active insurance group to ensure that: (i) The 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 (ii) Reasonable and effective mitigation measures are in place;

(B) Request, from any member of an internationally active insurance group subject to the commissioner's supervision, information necessary and appropriate to assess enterprise risk, including, but not limited to, information about the members of the internationally active insurance group regarding: (i) Governance, risk assessment and management, (ii) Capital adequacy, and (iii) Material intercompany transactions;

(C) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of such internationally active insurance group that are engaged in the business of insurance;

(D) Communicate with other state, federal and international regulatory agencies for members within the internationally active insurance group and share relevant information subject to the confidentiality provisions of section 38a-137 as amended by section 3 of this act, through supervisory colleges as set forth in subsection (n) of this section or otherwise;

(E) Enter into agreements with or obtain documentation from any insurer registered under this section, any member of the internationally active insurance group, and any other state,

federal and international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the commissioner's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state; and

(F) Other group-wide supervision activities, consistent with the authorities and purposes enumerated above, as considered necessary by the commissioner.

(6) If the commissioner acknowledges that another regulatory official from a jurisdiction that is not accredited by the NAIC is the group-wide supervisor, the commissioner is authorized to reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor, provided that:

(A) The commissioner's cooperation is in compliance with the laws of this state; and

(B) The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the commissioner's activities as a group-wide 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.

(7) The commissioner is authorized to enter into agreements with or obtain documentation from any insurer registered under this section, any affiliate of the insurer, and other state, federal and international regulatory agencies for members of the internationally active insurance group, that provide the basis for or otherwise clarify a regulatory official's role as group-wide supervisor.

(8) The commissioner may adopt such reasonable regulations in accordance with chapter 54 necessary for the administration of this subsection.

(9) A registered insurer subject to this subsection shall be liable for and shall pay the reasonable expenses of the commissioner's participation in the administration of this

subsection, including the engagement of attorneys, actuaries and any other professionals and all reasonable travel expenses.

Sec. 3. Subsection (a) of section 38a-137 of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2015)*:

(a) All information, documents, materials and copies thereof obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to section 38a-14a and all information reported, furnished or filed pursuant to sections 38a-135, as amended by section 2 of this act, and 38a-136 shall (1) be confidential by law and privileged, (2) not be subject to disclosure under section 1-210, (3) not be subject to subpoena, and (4) not be subject to discovery or admissible in evidence in any civil action. The commissioner shall not make such information, documents, materials or copies public without the prior written consent of the insurance company to which it pertains unless the commissioner, after giving the insurance company and its affiliates who would be affected thereby notice and opportunity to be heard, determines that the interests of policyholders, securityholders or the public will be served by the publication thereof, in which event the commissioner may publish all or any part thereof in such manner as the commissioner may deem appropriate. The commissioner may use such information, documents, materials or copies in the furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

Agency Legislative Proposal - 2015 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): CID1215CIGA-CLHIGA.doc

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

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

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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 definitions of "covered claim" and "insolvent insurer" to: (i) make technical changes; (ii) to specify that a covered claim includes one that arises out of a policy that was assumed by a licensed insurer via merger, assumption of assets and liabilities or assumption reinsurance and the insurer subsequently became an insolvent insurer; (iii) specifies that the residence of a claimant or insured that is not an individual shall be the state in which the principal place of business is located; (iv) to specify that a covered claim does not include any amount due under a policy that was originally issued by a surplus lines carrier or risk retention group; (v) to specify that a covered claim does not include any obligation assumed by an insurer after the commencement of receivership proceedings unless it would have been a covered claim absent such assumption; (vi) to specify that a covered claim does not include any obligation assumed by an insolvent insurer in a transaction in which the original insurer remains separately liable; (vii) to specify that the term insolvent insurer requires the insurer to be 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 to (i) make technical changes; and (ii) 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, 2015.

Sec. 3 makes a technical change to Conn. Gen. Stat. § 38a-843(a) and (b).

Sec. 4 amends the CLHIGA Act Conn. Gen. Stat. § 38a-860(f) 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.** **(1)** To reduce ambiguity in the law by amending the definition of "covered claim" to specify when there will be CIGA coverage for claims arising out of policies written by one insurer that were subsequently assumed by another insurer which becomes insolvent and to clarify state of residence. **(2)** The guaranty association statutes in most states, but not Connecticut, define an insolvent insurer in terms of a final order of liquidation with a finding of insolvency. The CIGA Act currently only requires a declaration of insolvency by a court of competent jurisdiction to trigger CIGA to respond to the insolvency. Section 1 will change the CIGA Act to require a final order of liquidation with a finding of insolvency in order for CIGA to be activated. Doing so will avoid the problem that arose from the March 11, 2013 court order of rehabilitation entered in Delaware with respect to Ullico Casualty Company containing a finding of insolvency which unintentionally triggered guaranty associations in several states including CIGA. The rehabilitator of Ullico suspended certain claim payments, but did not have access to the claim files and basic policyholder information to timely transmit the information to CIGA (and other affected guaranty associations). Without such information, CIGA could not directly inform Ullico insureds in Connecticut of the need to secure a new policy of insurance because CIGA coverage is limited to covered claims existing prior to the determination of insolvency and arising within 30 days after the determination of insolvency. CIGA therefore had to publish notices in area newspapers about the March 11, 2013 Ullico order of insolvency and advising the insureds to find replacement insurance. Ullico was subsequently placed into liquidation on May 30, 2013. This proposal (2) is a legislative resubmission - see HB 5253 sec. 1 (2014 session).

Sec. 2. Raising the limit of coverage to $500,000 (coverage for workers compensation is not subject to this limit) 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. At least 9 nine states currently provide the same or higher level of coverage. This change is of great importance to those few consumers who may face a large insurance claim, such as the loss of their home by fire and then have misfortune to have their insurer become insolvent. This section is a legislative resubmission. See HB 5253 § 2 (2014 session).

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 HB 5253 sec. 4 (2014 session); 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, in part. Section 1, part of section 2 and section 3 will help the administrators of CIGA. Sec. 4 is supported by members of CLHIGA.**

(4) *What would happen if this was not enacted in law this session?* **We would seek its enactment in the next session.**

Also, the change in section 4 will eliminate ambiguity in the CLHIGA statute and avoid the expense of litigation to resolve the coverage issue which is a cost that is ultimately offset from the premium taxes paid to the State.

- **Origin of Proposal** **X__ New Proposal / Part of Sec. 1.** **X__ Resubmission / Sec. 2-4**

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 Sec. 4 concerning the CLHIGA Act was submitted to the legislature as part of the Department's Technical Revisions bill SB 1093 §20. It passed the Senate unanimously and languished on the House calendar. In 2014, HB 5253 died in the Insurance and Real Estate Committee.**

(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 died in the Insurance and Real Estate Committee after its public hearing.**

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 and 3. 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. 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. 4. 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 if this legislation is passed. If section 4 is not enacted, there will remain ambiguity in the CLHIGA statute and CLHIGA may incur the expense of litigation to resolve the coverage issue which may arise in the future which will be a cost that is ultimately offset from the premium taxes paid to the State by members of CLHIGA.**
Federal **No fiscal impact.**

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

Insert fully drafted bill here

AN ACT CONCERNING THE CONNECTICUT INSURANCE GUARANTY ASSOCIATION AND THE CONNECTICUT LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION.

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

Section 1. Subdivisions (5) and (6) of section 38a-838 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(5)(A) "Covered claim" means an unpaid claim, including [, but not limited to,] one for unearned premiums, [which] that (i) arises out of and is within the coverage and subject to the applicable limits of an insurance policy to which sections 38a-836 to 38a-853, inclusive, apply [issued by an insurer, if such] if the insurer becomes an insolvent insurer [after October 1, 1971], or (ii) arises out of and is within the coverage and subject to the applicable limits of an insurance policy to which sections 38a-836 to 38a-853, inclusive apply that has been assumed as a direct obligation by an insurer who has been declared to be an insolvent insurer, where such obligation is assumed through a merger or acquisition, or pursuant to an acquisition of assets and assumption of liabilities, or

assumption reinsurance transaction and [(A)] (i) the claimant or insured is a resident of this state at the time of the insured event; or [(B)] (ii) the claim is a first party claim for damage to property with a permanent location in this state. [, provided the term "covered claim" shall] For purposes of this subparagraph, the residence of a claimant or insured that is not an individual shall be the state in which such claimant's or insured's principal place of business is located at the time of the insured event.

(B) "Covered claim" does not include (i) any claim by or for the benefit of any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise; provided that a claim for any such amount, asserted against a person insured under a policy issued by an insurer which has become an insolvent insurer, which, if it were not a claim by or for the benefit of a reinsurer, insurer, insurance pool or underwriting association, would be a "covered claim" may be filed directly with the receiver of the insolvent insurer but in no event shall any such claim be asserted against the insured of such insolvent insurer, (ii) any claim by or on behalf of an individual who is neither a citizen of the United States nor an alien legally resident in the United States at the time of the insured event, or an entity other than an individual whose principal place of business is not in the United States at the time of the insured event, and it arises out of an accident, occurrence, offense, act, error or omission that takes place outside of the United States, or a loss to property normally located outside of the United States or, if a workers' compensation claim, it arises out of employment outside of the United States, (iii) any claim by or on behalf of a person who is not a resident of this state, other than a claim for compensation or any other benefit which arises out of and is within the coverage of a workers' compensation policy, against an insured whose net worth at the time the policy was issued or at any time thereafter exceeded twenty-five million dollars, provided that an insured's net worth for purposes of this section and section 38a-844 shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis, (iv) any claim by or on behalf of an affiliate of the insolvent insurer at the time the policy was issued or at the time of the insured event, [or] (v) any claim arising out of a policy issued by an insurer which was not licensed to transact insurance in this state either at the time the policy was issued, when the obligation with respect to the covered claim was assumed, or when the insured event occurred; (vi) any amount due under any policy originally issued by a surplus lines carrier or risk retention group; (vii) any obligation assumed by an insolvent insurer after the commencement of any

delinquency proceedings, as defined in section 38a-905 involving the insolvent insurer or the original insurer, unless it would have been a covered claim absent such assumption; or (viii) any obligation assumed by an insolvent insurer in a transaction in which the original insurer remains separately liable.

(6) "Insolvent insurer" means an insurer (A) (i) licensed to transact insurance in this state either at the time the policy was issued, when the obligation with respect to the covered claim was assumed, or when the insured event occurred, and (ii) [determined to be insolvent] against which a final order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction in the insurer's state of domicile; (B) [which] that 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) [determined to be insolvent] against which a final order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction in the insurer's state of domicile; or (C) [which] that (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) is determined to be insolvent by a court of competent jurisdiction] provided such division is approved (I) in a jurisdiction that allows such division, and (II) by an insurance regulator having jurisdiction over such division, and (ii) against which a final order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction in the succeeding insurer's state of domicile. "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, 2015*):

(a) Said association shall: (1) Be obligated to the extent of the covered claims existing prior to the [determination of insolvency] entry of the final order of liquidations with a

finding of insolvency and arising within thirty days after the [determination of insolvency] entry of such order, or before the policy expiration date if less than thirty days after the [determination] entry of such order, or before the insured replaces the policy or causes its cancellation, if [he] the insured does so within thirty days of [such determination] such 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] this is in excess of one hundred dollars and is less than (i) three hundred thousand dollars for claims arising under policies of insurers determined to be insolvent prior to October 1, 2007, [and] (ii) 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, 2015, and (iii) five hundred thousand dollars for claims arising under policies of insurers against which a final order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction on or after October 1, 2015, 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)] (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)] (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. Subsections (a) and (b) of section 38a-843 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) The commissioner shall: (1) Notify said association of the existence of an insolvent insurer, and notify the chairman of the Workers' Compensation Commission and the State Treasurer of the existence of an insolvent workers' compensation insurer, not later than three days after [he] the commissioner receives notice [of the determination] of any such insolvency; (2) upon request of the board of directors, provide said association with a statement of the net direct written premiums of each member insurer.

(b) The commissioner may: (1) Require that said association notify those persons insured by the insolvent insurer, and any other interested parties, of the [determination] entry of a final order of liquidation with a finding of insolvency and of their rights under sections 38a-836 to 38a-853, inclusive. Such notification shall be by mail sent to their last known address, where available, provided if sufficient information for such notification by mail is not available, notice by publication in a newspaper of general circulation shall be sufficient to satisfy the requirements of this subsection; (2) suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or which fails to comply with said plan of operation. In lieu of such suspension or revocation, the commissioner may levy a fine on any member insurer which fails to pay an assessment when due, provided no such fine shall exceed five per cent of the unpaid assessment per month, and provided no fine shall be less than five hundred dollars per month; (3)

revoke the designation of any servicing facility if the commissioner finds claims are being handled unsatisfactorily.

Sec. 4. Subsection (f) of section 38a-860 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(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] 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] <u>(i) a</u> 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] <u>that</u> 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, 42 USC 1395w21 et seq., or Part D, 42 USC 1395w101 et seq., as both may be amended from time to time, or any regulations issued thereunder.

Agency Legislative Proposal - 2015 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): CID1214MarketConduct.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
122014

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 work paper confidentiality and immunity.

This allows us to ensure that the work papers reviewed 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?
The lack of workpaper confidentiality impairs our ability to lead multi-state exams

- **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?

(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?
Did not get out of committee last year- concerns re consultant costs

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
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)

Will protect workpaper confidentiality

AN ACT CONCERNING THE INSURANCE DEPARTMENT'S MARKET CONDUCT EXAMINATION AUTHORITY.

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. Any such examination shall be conducted in accordance with the procedures and definitions set forth in the National Association of Insurance Commissioners' Market Regulation Handbook.

(b) To carry out the examinations under this section, the commissioner may appoint, as market conduct examiners, one or more competent persons, **[**not officers**]** 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 **[**an**]** 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 his**]** in such person's custody, deemed to be relevant to the examination, for the inspection of the commissioner, **[**his**]** the commissioner's actuary or examiners, when required. The officers and agents of the company, center, **[**or association**]** 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, administratoror society, its officers or agents. The commissioner shall grant a hearing to the company, center, administrator or society examined **[**,**]** before filing any such report **[**,**]** and may withhold any such report from public inspection for such time as the commissioner deems proper. The commissioner may, if **[**he**]** the commissioner deems it in the public interest, publish any such report, or the result of any such examination contained therein, in one or more newspapers of the state.

(d) 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) No cause of action shall arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representative or any examiner appointed or engaged by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this section.

(2) No cause of action shall arise nor shall any liability be imposed against any person for the act of communicating or delivering information or data pursuant to an examination made under the authority of this section to the commissioner, the commissioner's authorized representative or an examiner if such communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(3) This subsection shall not abrogate or modify any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subdivision (1) of this subsection.

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

(g) All workpapers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the commissioner or any other person in the course of an examination made under the authority of this section shall be confidential by law and privileged, shall not be subject to disclosure under section 1-210 of the general statutes, shall not be subject to subpoena, shall not be subject to discovery and shall not be made public by the commissioner or any other person except to the extent provided in subsection (g) of this section. The commissioner may grant access to such workpapers, recorded information, documents and copies to the National Association of Insurance Commissioner as long as it agrees, in writing, to hold such workpapers, recorded information, documents and copies confidential.

Agency Legislative Proposal - 2015 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): CID1215ORSA.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
Statutory Reference
Proposal Summary Amend Sec. 2(h) of Public act 14-107 to enable the Commissioner to share ORSA reports with other regulators without written permission of the carriers. Will create more conformity with the NAIC ORSA Model law.
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?

- **Origin of Proposal** **___ 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:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

NAIC ORSA Model is anticipated to be an accreditation requirement sometime before 1/1/18. If this correction is not made it could impact the Department's accreditation status.

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)

State

Federal

Additional notes on fiscal impact

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

Insert fully drafted bill here

Subsection (h) of section 1 of Public Act 14-107 is repealed and the following is substituted in lieu thereof :

(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] prior notice to 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) (1) To assist the commissioner in the performance of the commissioner's regulatory duties, the commissioner:

(A) 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, with (i) other state, federal and international regulatory officials, including members of a supervisory college as described in section 38a-135 of the general

statutes, (ii) NAIC, and (iii) 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] provides notice to the insurer prior to sharing any such documents, materials or other information;

(B) 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

(C) 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 subparagraph (A) or (B) of this subdivision. Any such agreement shall (i) specify policies and procedures regarding the confidentiality and security of such documents, materials or other information that are shared with NAIC or a third-party consultant, including (I) 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, and (II) a provision requiring NAIC or a third-party consultant to agree, in writing, and if applicable, a provision requiring NAIC to obtain from a regulatory official under subparagraph (C)(i)(I) of this subdivision an agreement, in writing, to maintain the confidentiality and privileged status of such documents, materials or other information, and verifying the recipient's legal authority to maintain confidentiality; (ii) 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; (iii) 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; (iv) 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 (v) 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 subparagraph (A) of this subdivision, to allow such insurer to intervene in any judicial or administrative action regarding such disclosure.

Agency Legislative Proposal - 2015 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): CID1214PremiumRefundInterest.doc

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

State Agency: Connecticut Insurance Department
CID

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

Lead agency division requesting this proposal:
Consumer Affairs

Agency Analyst/Drafter of Proposal: Beth Cook

Title of Proposal
AAC Consumer Protections

Statutory Reference
38a-591d(e); 38a-816

Proposal Summary

38a-816 – require interest payments on premium refunds for individual health insurance policyholders

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? These provide additional protections and transparency; there would be no negative impact if not enacted

- **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: 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)

38a-816 – requires carriers to timely provide refunds and requires interest on payments not timely made; should encourage carriers to be more prompt in providing refunds. We have had some complaints that carriers are holding onto refunds for us to 90 days.

AAC Consumer Protections

Sec. 2. Sec. 38a-816 of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof:

(23) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity which delivers or issues for delivery, continues or renews in this state any individual policy, as defined in sections 38a-469, shall refund upon request any overpaid premium made by a policyholder for coverage under such policy. Refunds shall be timely processed following notice of cancellation of the policy or upon receipt of request from the policyholder. Any refund issued more than thirty days following such notice shall provide interest at the rate of fifteen per cent per annum.

Agency Legislative Proposal - 2015 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): CID1214RiskRetentionGroups.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 Risk Retention Groups.

Statutory Reference: Conn. Gen. Stat. §§ 38a-250 to 38a-253, inclusive, Conn. Gen. Stat. § 38a-255.

Proposal Summary

This proposal will amend provisions within Chapter 698e concerning risk retention groups to closely track with provisions of the National Association of Insurance Commissioners (NAIC) Model Risk Retention Act.

Sec. 1 amends the Section 38a-250(8) definition "plan of operation or a feasibility study" to specify that the analysis contained in any such plan or study shall include activities for each state in which the risk retention group (RRG) intends to operate.

Sec. 2 amends Conn. Gen. Stat. § 38a-250 to add a definition of "NAIC".

Sec. 3 amends Conn. Gen. Stat. § 38a-251 concerning the licensure and regulation of RRGs chartered in this state. New provisions in **subsection (b)** will require RRGs to submit for the Commissioner's approval an appropriate revision within ten days of any subsequent material change in any item of the plan of operation or in the feasibility study, and the RRG may not offer any additional kinds of liability insurance in any state until such revision is approved. New provisions in **subsection (c)** will require RRGs to provide the Commissioner at the time of filing its application for a charter, information on the identity of the initial members of the RRG, the RRG organizers, persons who will provide administrative services or otherwise influence or control coverages to be afforded, and the states in which the RRG intends to operate. New provisions in **subsection (d)** will establish corporate governance standards (a majority of independent directors on the RRG board of directors, audit committee, adoption and disclosure of governance standards, adoption of business conduct and ethics for officers, directors and employees, and reporting of material non-compliance of such standards to the Commissioner.

Sec. 4 makes minor changes to Conn. Gen. Stat. § 38a-253 concerning submission of information to the

Commissioner from RRGs domiciled outside Connecticut.

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

PROPOSAL BACKGROUND

Reason for Proposal: In 1987, Connecticut enacted statutes based on the NAIC Model Risk Retention Act to regulate the formation and operation of risk retention groups (RRGs) formed pursuant to the provisions of the federal Liability Risk Retention Act of 1986 (LRRA). LRRA allows businesses with similar risk exposures to create their own insurance company, a RRG, to self-insure their commercial liability risks on a group basis and establishes a regulatory framework that partially preempts state insurance laws. LRRA allows the RRG to be regulated primarily by its chartering (domiciliary) state even when the RRG sells insurance coverage in other states.

The NAIC Model Risk Retention Act has been revised periodically and most recently, in 2011 to establish corporate governance standards for RRGs. These standards were developed by the NAIC following a 2005 report to the U.S. Congress by the Government Accountability Office that the regulation of RRGs was deficient because there were no clear regulatory requirements for RRGs to operate using sound corporate governance principles. This year, the NAIC Financial Regulation Standards and Accreditation Program revised its standards to require states to have laws that are substantially similar to the NAIC Model Risk Retention Act provisions governing corporate governance principles (NAIC Model Act § 3.D.) by January 1, 2017. These standards are contained in Section 4(d) of this legislative proposal. The other proposed changes in this proposal simply updates provisions of Connecticut law to track with the NAIC Model Act and in doing so, further enhances the effectiveness of the Department's regulation of RRGs for the protection of Connecticut consumers.

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)?* **Most states have adopted some version of the NAIC Model Risk Retention Act. All states with RRGs can be expected to seek legislation to adopt the corporate governance provisions to comply with NAIC accreditation requirements.**

(3) *Have certain constituencies called for this action?* **Yes. The NAIC.**

(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:

(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.**

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

Insert fully drafted bill here

AN ACT CONCERNING RISK RETENTION GROUPS.

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

Section 1. Subdivision (8) of section 38a-250 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(8) "Plan of operation or a feasibility study" means an analysis which presents the expected activities and results of a risk retention group including, at a minimum, (A) for each state in which it intends to operate, the coverages, deductibles, coverage limits, rates and rating classification systems for each line of insurance the group intends to offer, (B) historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available, (C) pro forma financial statements and projections, (D) appropriate opinions by an independent member of the American Academy of Actuaries, including a determination of minimum premium or participation levels required to commence

operations and to prevent a hazardous financial condition, (E) information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations, (F) identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies and reinsurance agreements, (G) identification of each state in which the risk retention group has obtained, or sought to obtain, a charter and license, and a description of its status in each such state, and (H) such other matters as may be prescribed by the commissioner of the state in which the risk retention group is chartered for liability insurance companies authorized by the insurance laws of that state;

Sec. 2. Section 38a-250 of the general statutes is amended by adding subdivision (13) as follows:

(NEW) (*Effective October 1, 2015*) (13) "NAIC" means the National Association of Insurance Commissioners.

Sec. 3. Section 38a-251 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) A risk retention group seeking to be chartered in this state must be chartered and licensed as a liability insurance company authorized by the insurance laws of this state and, except as provided in sections 38a-250 to 38a-266, inclusive, shall comply with all of the laws, rules, regulations and requirements applicable to such insurers chartered and licensed in this state, and with section 38a-252 to the extent such requirements are not a limitation on laws, rules, regulations or requirements of this state.

(b) Before it may offer insurance in any state, each risk retention group shall also submit for approval to the Insurance Commissioner of this state a plan of operation or a feasibility study. The risk retention group shall submit an appropriate revision in the event of any material change in any item of the plan of operation or in the feasibility study, within ten days of any such change. The group shall not offer any additional kinds of liability insurance, in this state or in any other state, until a revision of the plan is approved by the Commissioner [and revisions of such plan or study if the group intends to offer any additional lines of liability insurance].

(c) At the time of filing its application for charter, the risk retention group shall provide to the Commissioner in summary form the following information: the identity of the initial members of the group, the identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control coverages to be afforded, and the states in which the group intends to operate. Upon receipt of this information, the Commissioner shall forward the information to the NAIC. Providing notification to the NAIC is in addition to and shall not be sufficient to satisfy the requirements of section 38a-252 or any other provision of sections 38a-250 to 38a-266, inclusive.

(d) Governance Standards for Risk Retention Groups. Within a year of the effective date of this act, existing risk retention groups shall be in compliance with the following governance standards. New risk retention groups shall be in compliance with the standards at the time of licensure.

(1) Board of Directors. The "board of directors" or "board" as used in this section, means the governing body of the risk retention group elected by the shareholders or members to establish policy, elect or appoint officers and committees, and make other governing decisions. "Director" as used in this section, means a natural person designated in the articles of the risk retention group, or designated, elected or appointed by any other manner, name or title to act as a director.

(A) Independent Directors. The board of directors of the risk retention group shall have a majority of independent directors. If the risk retention group is a reciprocal, then the attorney-in-fact would be required to adhere to the same standards regarding independence of operation and governance as imposed on the risk retention group's board of directors/subscribers advisory committee under these standards; and, to the extent permissible under state law, service providers of a reciprocal risk retention group should contract with the risk retention group and not the attorney-in-fact. No director qualifies as "independent" unless the board of directors affirmatively determines that the director has no "material relationship" with the risk retention group. Each risk retention group shall disclose these determinations to its domestic regulator, at least annually. For this purpose, any person that is a direct or indirect owner of or subscriber in the risk retention group (or is an officer, director and/or employee of such an owner and insured, unless some other position of such officer, director and/or employee constitutes a "material relationship"), as contemplated by Section 3901(a)(4)(E)(ii) of the Liability Risk Retention Act, is considered to be "independent".

(B) "Material relationship" of a person with the risk retention group includes, but is not limited to: (i) The receipt in any one twelve-month period of compensation or payment of any other item of value by such person, a member of such person's immediate family or any business with which such person is affiliated from the risk retention group or a consultant or service provider to the risk retention group is greater than or equal to five percent of the risk retention group's gross written premium for such twelve-month period or two percent of its surplus, whichever is greater, as measured at the end of any fiscal quarter falling in such a twelve-month period. Such person or immediate family member of such person is not independent until one year after his or her compensation from the risk retention group falls below the threshold. (ii) A relationship with an auditor as follows: a director or an immediate family member of a director who is affiliated with or employed in a professional capacity by a present or former internal or external auditor of the risk retention group is not independent until one year after the end of the affiliation, employment or auditing relationship. (iii) A relationship with a related entity as follows: a director or immediate family member of a director who is employed as an executive officer of another company where any of the risk retention group's present executives serve on that other company's board of directors is not independent until one year after the end of such service or the employment relationship.

(2) Service Provider Contracts. The term of any material service provider contract with the risk retention group shall not exceed five years. Any such contract, or its renewal, shall require the approval of the majority of the risk retention group's independent directors. The risk retention group's board of directors shall have the right to terminate any service provider, audit or actuarial contracts at ay time for cause after providing adequate notice as defined in the contract. The service provider contract is deemed material if the amount to be paid for such contract is greater than or equal to five percent of the risk retention group's annual gross written premium or two percent of its surplus, whichever is greater.

(A) For purposes of this standard, "service providers" shall include captive managers, auditors, accountants, actuaries, investment advisors, lawyers, managing general underwriters or other party responsible for underwriting, determination of rates, collection of premium, adjusting and settling claims and/or the preparation of financial statements. Any reference to "lawyers" in the prior sentences does not include

defense counsel retained by the risk retention group to defend claims, unless the amount of fees paid to such lawyers are "material" as defined in this subsection.

(B) No service provider contract meeting the definition of "material relationship" contained in this subsection shall be entered into unless the risk retention group has notified the Commissioner in writing of its intention to enter into such transaction at least thirty days prior thereto and the Commissioner has not disapproved it within such period.

(3) Written Policy. The risk retention group's board of directors shall adopt a written policy in the plan of operation approved by the board that requires the board to: (A) assure that all owner/insureds of the risk retention group receive evidence of ownership interest; (B) develop a set of governance standards applicable to the risk retention group; (C) oversee the evaluation of the risk retention group's management including but not limited to the performance of the captive manager, managing general underwriter or other party or parties responsible for underwriting, determination of rates, collection of premium, adjusting or settling claims or the preparation of financial statements; (D) review and approve the amount to be paid for all material service providers; and (E) review and approve, at least annually: (i) risk retention group's goals and objectives relevant to the compensation of officers and service providers: (ii) the officers' and service providers; performance in light of those goals and objectives; and (iii) the continued engagement of the officers and material service providers.

(4) Audit Committee. The risk retention group shall have an audit committee composed of at least three independent board members as defined in this subsection. A non-independent board member may participate in the activities of the audit committee, if invited by the members, but cannot be a member of such committee.

(A) The audit committee shall have a written charter that defines the committee's purpose, which, at a minimum, must be to: (i) assist board oversight of a. the integrity of the financial statements, b. the compliance with legal and regulatory requirements, and c. the qualifications, independence and performance of the independent auditor and actuary; (ii) discuss the annual audited financial statements and quarterly financial statements with management; (iii) discuss the annual audited financial statements with its independent auditor and, if advisable, discuss its quarterly financial statements with its independent auditor; (iv) discuss policies with respect to risk assessment and risk management; (v) meet separately and periodically, either directly or through a designated representative of the committee, with management and independent

auditors; (vi) review with the independent auditor any audit problems or difficulties and management's response; (vii) set clear hiring policies of the risk retention group as to the hiring of employees or former employees of the independent auditor; (viii) require the external auditor to rotate the lead (or coordinating) audit partner having primary responsibility for the risk retention group's audit as well as the audit partner responsible for reviewing that audit so that neither individual performs audit services for more than five consecutive fiscal years; and (ix) report regularly to the board of directors.

(B) The domestic regulator may waive the requirement to establish an audit committee composed of independent board members if the risk retention group is able to demonstrate to the domestic regulator that it is impracticable to do so and the risk retention group's board of directors itself if otherwise able to accomplish the purposes of an audit committee, as described in this subdivision.

(5) Governance Standards. The board of directors shall adopt and disclose governance standards, where "disclose" means making such information available through electronic (e.g., posting such information on the risk retention group's website) or other means, and providing such information to members/insureds upon request, which shall include: (A) a process by which the directors are elected by the owner/insureds; (B) director qualification standards; (C) director's responsibilities; (D) director access to management and, as necessary and appropriate, independent advisors; (E) director compensation; (F) director orientation and continuing education; (G) the policies and procedures that are followed for management succession; and (H) the policies and procedures that are followed for annual performance evaluation of the board.

(6) Business Conduct and Ethics. The board of directors shall adopt and disclose a code of business conduct and ethics for directors, officers and employees and promptly disclose to the board of directors any waivers of the code for directors or executive officers, which should include the following topics: a. conflicts of interest; b. matters covered under the corporate opportunities doctrine under the state of domicile; c. confidentiality; d. fair dealing; e. protection and proper use of risk retention group assets; f. compliance with all applicable laws, rules and regulations; and g. requiring the reporting of any illegal or unethical behavior which affects the operation of the risk retention group.

(7) Reporting Non-Compliance. The captive manager, president or chief executive officer of the risk retention group shall promptly notify the domestic regulator in writing if either becomes aware of any material non-compliance with any of these governance standards.

Sec. 4. Section 38a-252 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) Notice of Operations and Designation of Commissioner as Agent. Risk retention groups chartered in states other than this state and seeking to do business as a risk retention group in this state shall, prior to offering insurance in this state submit to the Insurance Commissioner: (1) A statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, date of chartering, its principal place of business, and such other information, including information on its membership, as the commissioner may require to verify that the risk retention group satisfies the definitional requirements of subdivision (11) of section 38a-250; (2) a copy of its plan of operations or a feasibility study and revisions of such plan or study submitted to its state of domicile, provided the provision relating to the submission of a plan of operation or a feasibility study shall not apply with respect to any line or classification of liability insurance which (A) was defined in the Product Liability Risk Retention Act of 1981 before the date of the enactment of the Liability Risk Retention Act of 1986, and (B) was offered before such date by any risk retention group which had been chartered and operating for not less than three years before such date; and (3) a statement of registration which designates the commissioner as its agent for the purpose of receiving service of legal documents or process.

(b) Revision to Plan of Operation or Feasibility Study. The risk retention group shall submit a copy of any material revision to its plan of operation or feasibility study required by subsection (b) of section 38a-251 within thirty days of the date of the approval of such revision by the Commissioner of its chartering state, or if no such approval is required, within thirty days of filing.

Sec. 5. Section 38a-253 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) Each risk retention group not domiciled in this state that is doing business in this state shall submit to the Insurance Commissioner: (1) A copy of the group's financial statement submitted to its state of domicile, which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist under criteria established by the NAIC; (2) a copy of each examination of the risk retention group as certified by the commissioner or public official conducting the examination; (3) upon request by the commissioner, a copy of any information or document pertaining to any outside audit performed with respect to the risk retention group; and (4) such information as may be required to verify that it satisfies the definitional requirements of subdivision (11) of section 38a-250.

(b) Each risk retention group doing business in this state shall, annually, on or before the first day of March, submit to the commissioner, by electronically filing with the National Association of Insurance Commissioners, a true and complete report, signed and sworn to by its president or a vice president, and secretary or an assistant secretary, of its financial condition on the thirty-first day of December next preceding, prepared as submitted to its state of domicile.

(c) Each risk retention group shall submit to an examination by the Insurance Commissioner to determine its financial condition if the commissioner of the jurisdiction in which the group is chartered and licensed has not initiated an examination or does not initiate an examination within sixty days after a request by the Insurance Commissioner of this state. Any such examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the National Association of Insurance Commissioners' Examiner Handbook.

Sec. 6. Section 38a-255 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

[Any] Every application form for insurance from a risk retention group, and every policy issued by a risk retention group shall contain in ten point type on the front page and the declaration page, the following notice:

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

Agency Legislative Proposal - 2015 Session

Document Name (e.g. OPM1015Budget.doc;OTG1015Policy.doc):
CID1214HealthInsuranceStatutesUpdate.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:
Life and Health

Agency Analyst/Drafter of Proposal:
Mary Ellen Breault

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.

Sections 8 through 11.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 12 through 17.These changes all relate to Connecticut's existing small group laws.

Section 12 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 8 through 11).

Section 13 amends section 38a-566 as the Affordable Care Act has different requirements for sole proprietors.

Section 15 amends section 38a-567 to make it consistent with the rating requirements for small group plans under the Affordable Care Act.

Section 16 amends section 38a-569 related to the Connecticut Small Employer Health Insurance Pool and deletes obsolete subsections.

Section 17 amends section 38a-574 as medical underwriting is not permitted under the Affordable Care Act.

Sections 18-31 were drafted by LCO as part of SB 478 to amend sections of the law that reference changes made to HRA and small employer laws.

Section 32 amends 38a-543 to clarify that a group health insurance policy cannot reduce benefits for those eligible for Medicare unless the individual is enrolled in and receiving benefits from Medicare.

Sections 33 and 34 repeal sections of the law relating to the HRA and small employer market that are no longer needed or allowed due to changes in the Affordable Care Act.

Section 35 is new and applies to individual policies. Similar to the change in Section 32 for group health insurance, this provision clarifies that an individual health insurance policy cannot reduce benefits for those eligible for Medicare unless the individual is enrolled in and receiving benefits from Medicare.

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** **___ 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?
Time

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
Insurance industry was supportive of changes

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
CID, industry, administering company for pools

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

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)

Sec 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.

Sec 2. Section 38a-476 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):
(a) **[**(1)**]** For the purposes of this section: **[**, "health**]**

(1) "Health insurance plan" means any hospital and medical expense incurred policy, hospital or medical service plan contract and health care center subscriber contract. **[**and**]** "Health insurance plan" 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 from time to time, except for any such arrangement **[**which**]** that is fully insured within the meaning of Section 514(b)(6) of said act, as amended from time to time.

(3) "Preexisting conditions provision" means a policy provision **[**which**]** that 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**]** such 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) (1) 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**]** that imposes a preexisting conditions provision shall be subject to the following conditions: **[**(1)**]** (A) No such preexisting conditions provision shall exclude coverage beyond twelve months following the insured's effective date of coverage; **[**(2)**]** (B) 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)**]** (C) 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."

(2) 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**]** that impose 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.**]**

Sec 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.

Sec. 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) For purposes of this section, "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148 as amended from time to time, and regulations adopted thereunder. Any such policy that is subject to the Affordable Care Act 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 Affordable Care Act.

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

(7) The total premium for family coverage for policies subject to the Affordable Care Act 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.

Sec. 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, as amended by this act, 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.

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

(a) (1) 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] may 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]. 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 that are unfair or deceptive or that 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) No group health insurance policy or certificate for a small employer, as defined in section 38a-564, as amended by this act, shall be issued or delivered in this state unless the premium rates have been submitted to and approved by the commissioner. Premium rate filings shall include an actuarial memorandum that includes, but is not limited to, (A) pricing assumptions and claims experience, and

(B) premium rates and loss ratios from the inception of the policy.

(b) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity **[**which**]** that 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**]** that 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.

Sec. 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.**]**

Sec. 8. Section 38a-551 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

For the purposes of this section and sections 38a-552, as amended by this act, and 38a-556 to 38a-559, inclusive, as amended by this act, the following terms **[**shall**]** have the following meanings:

[(a)**]** (1) "Health insurance" or "health care plan" 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"**]** "Health insurance" or "health care plan" does not include **[**(1)**]** (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 **[**(2)**]** (B) policies of specified disease or limited benefit health insurance, provided: **[**(A)**]**
(i) The carrier offering such policies files on or before March first of each year a certification with the commissioner that contains the following: **[**(i)**]** (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)**]** (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)**]** (ii) 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)**]** (B)(i) of this subdivision at least thirty days prior to the date such policy is issued or delivered in this state.

[(b)**]** (2) "Carrier" means an insurer, health care center, hospital service corporation or medical service corporation or fraternal benefit society.

[(c)**]** (3) "Insurer" means an insurance company licensed to transact accident and health insurance business in this state.

[(d)**]** (4) "Health care center" **[**means a health care center, as defined**]** has the same meaning as provided in section 38a-175.

[(e)**]** (5) "Self-insurer" or "self-insured or self-funded employee health benefit plan" means an employer or an employee welfare benefit fund or plan **[**which**]** that 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, "selfinsurer" shall**]** "Self-insurer" or "self-insured or self-funded employee health benefit plan" does not include any such employee welfare benefit fund or plan established prior to April 1, 1976, by any organization **[**which**]** that 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)**]** (6) "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)**]** (7) "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**]** that 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**]** "Resident employer" refers 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)**]** (8) "Resident" means **[**(1) a person**]** an individual 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) "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).**]**

(9) "Special health care plan" means a health insurance plan issued by the Health Reinsurance Association established under section 38a-556, as amended by this act, for low-income individuals.

(10) "Low-income individual" means an individual whose family income is less than three hundred per cent of the federal poverty level for the calendar year prior to the date of application for an individual special health care plan or the year prior to the anniversary of the effective date of such plan, as certified by such individual.

(11) "Reimbursement rate" means, with respect to an individual special health care plan, (A) seventy-five per cent of the reimbursement rate payable under Medicare for benefits normally reimbursable under Medicare, or (B) for services and supplies that are not reimbursed by Medicare, seventy-five per cent of the amount that would be payable under Medicare if Medicare was responsible for payment for such services or supplies, as estimated by the board of directors of the Health Reinsurance Association and approved by the Insurance Commissioner.

Sec. 9. Section 38a-552 of the general statutes is repealed and the following is substituted in lieu thereof (*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 38a556, 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 38a555, 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.**]**
No individual or organization that provides medical advice, diagnosis, care or treatment of a type covered under a special health care plan shall 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 individuals or their dependents covered under such special health care plans.

Sec.10. Section 38a-556 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

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

[(a)**]** (b) (1) The board of directors of the association shall be made up of nine individuals selected by participating members, subject to approval by the commissioner, two of whom shall be appointed by the commissioner on or before July 1, 1993, to represent health care centers. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the net health insurance premium derived from this state in the previous calendar year. If the board of directors is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial board. In approving or selecting members of the board, the commissioner may consider, among other things, whether all members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services.

(2) The board shall submit to the commissioner a plan of operation for the association necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation shall become effective upon approval in writing by the commissioner. **[**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**]** Such plan shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner. The plan of operation shall: **[**, 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; and (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)**]** 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. 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**]** other state or federal programs that may be established.

[(b)**]** (c) The association shall have the general powers and authority granted under the laws of this state to carriers to transact the kinds of insurance defined under section 38a-551, and in addition thereto, the specific authority to: (1) Enter into contracts necessary or proper to carry out the provisions and purposes of this section and sections **[**38a-505, 38a-546 and**]** 38a-551, as amended by this act, and 38a-556a 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 this section and sections **[**38a-505, 38a-546 and**]** 38a-551, as amended by this act, and 38a-556a 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; and (13) perform such other duties and responsibilities as may be required by state or federal law or permitted by state or federal law and approved by the Insurance Commissioner.

[(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)**]**

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

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

(3) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association and the association shall have an annual audit of its operations by an independent certified public accountant. The annual audit shall be filed with the commissioner for his review and the association shall be subject to the provisions of section 38a-14.

[(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)**]** (f) All policy forms issued by or through the association shall conform in substance to prototype forms developed by the association, shall in all other respects conform to the requirements of this section and sections **[**38a-505, 38a-546 and**]** 38a-551, as amended by this act, and 38a-556a 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**]** that are unfair or deceptive or **[**which**]** that encourage misrepresentation of the policy.

[(f)**]** (g) 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, 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)**]** (h) 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)**]** (i) There shall be no liability on the part of and no cause of action of any nature shall arise against any carrier or its agents or its employees, the Health Reinsurance Association or its agents or its employees or the residual market mechanism established under the provisions of section 38a-557, as amended by this act, or its agents or its employees, or the commissioner or **[**his**]** the commissioner's representatives for any action taken by them in the performance of their duties under this section and sections **[**38a-505, 38a-546 and**]** 38a-551, as amended by this act, and 38a-556a 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.

Sec. 11. Section 38a-557 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Hospital service corporations and medical service corporations may **[**elect to meet the obligations of section 38a-552 by participating**]** participate in the Health Reinsurance Association established in section 38a-556, as amended by this act, as a full member thereof, or by making **[**comprehensive**]** health care plans available directly through a subscriber contract or combination of contracts or by forming a separate residual market mechanism substantially similar to **[**the association established in section 38a-556**]** said association.
(b) In the event that hospital service corporations and medical service corporations choose to form a separate residual market mechanism, the commissioner shall have the same regulatory powers over that residual market mechanism as the commissioner has over the Health Reinsurance Association, and such residual market mechanism shall have the same powers and duties as the association. Rating classifications under a residual market mechanism established under this section need not be the same as classifications established under the association, but any rates established by the residual market mechanism shall be approved by the commissioner. The commissioner shall **[**promulgate**]** adopt regulations in accordance with the provisions of chapter 54 to carry out the requirements of this section.

(c) If hospital service corporations and medical service corporations do not elect to participate in the Health Reinsurance Association, such service corporations shall be required to make an individual **[**comprehensive**]** health care plan available to every resident of this state except residents who are both sixty-five years of age or older and eligible for Medicare and whose coverage under a group or individual contract issued by such service corporations has

terminated. Such coverage may be made available through a separate residual market mechanism established under this section.

Sec. 12. 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**]** 38a-566, as amended by this act, 38a-567, as amended by this act, 38a-569, as amended by this act, and 38a-574, as amended by this act:

(1) "Pool" means the Connecticut Small Employer Health Reinsurance Pool, established under section 38a-569, as amended by this act.

(2) "Board" means the board of directors of the pool.

(3) ["Eligible employee"] "Employee" 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. 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.] , 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.

(B) "Small employer" does not include [(i) a 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**]** service corporation, medical service corporation **[**,**]** or health care center, authorized to transact health insurance business in this state.

(6) "Insurance arrangement" means any multiple employer welfare arrangement, as defined in Section 3 of the Employee Retirement Income Security Act of 1974, **[**(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**]** "Health insurance plan" does not include (A) accident only, credit, dental, vision, Medicare supplement, long-term

care or disability insurance, hospital indemnity coverage, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payments insurance, or insurance under which beneficiaries are payable without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, or (B) policies of specified disease or limited benefit health insurance, provided 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, as amended by this act.

[(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) "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)**]** (9) "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**]** includes 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, as amended by this act, or other applicable laws.

[(14)**]** (10) "Commissioner" means the Insurance Commissioner.

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

[(16)**]** (12) "Small employer carrier" means any insurer or insurance arrangement **[**which**]** that 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)**]** (13) "Health care center" **[**means health care center as defined**]** has the same meaning as provided in section 38a-175.

[(27)**]** (14) "Case characteristics" means demographic or other objective characteristics of a small employer, including age **[**, sex, family composition, location, size of group, administrative cost savings resulting from the administration of an association group plan or a plan written pursuant to section 5259 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**]** and geographic location. "Case characteristics" does not include claims experience, health status **[**, and**]** or 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.**]**

Sec. 13. 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-552, as amended by this act, 38a-564, as amended by this act, **[**to 38a-572, inclusive**]** 38a-567, as amended by this act, and 38a-569, as amended by this act, 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, as amended by this act, 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, as amended by this act, or subparagraph (A) of subdivision (2) of subsection **[**(e)**]**

(c) of section 38a-569, as amended by this act. **[**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."**]**

Sec. 14. 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.**]**

(1) (A) Any such plan or arrangement shall be offered on a guaranteed issue basis with respect to all eligible employees or dependents of such employees, 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**]** set forth in this subparagraph 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.**]**
(D) Any such plan or arrangement shall provide special enrollment periods (i) to all eligible employees or dependents as set forth in 45 CFR 147.104, as amended from time to time, and (ii) for coverage under such plan or arrangement ordered by a court for a spouse or minor child of an eligible employee where request for enrollment is made not later than thirty days after the issuance of such court order.

[(5) (A)**]** (2) (A) With respect to grandfathered plans **[**or arrangements issued on or after July 1, 1995**]** issued to small employers, the premium rates charged or offered **[**to small employers**]** shall be established on the basis of a **[**community rate**]** single pool of all 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;

(ii) Gender;

(iii) Geographic area, provided an area smaller than a county shall not be utilized;

(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, as amended by this act, 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**]** that writes small business plans or arrangements for an association group plan or a plan written pursuant to section 5-259, as amended by this act, 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.**]**

(B) (i) With respect to nongrandfathered plans issued to small employers, the premium rates charged or offered shall be established on the basis of a single pool of all nongrandfathered 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.

(ii) Total premium rates for family coverage for nongrandfathered plans shall be determined by adding the premiums for each individual family member, except that with respect to family members under twenty-one years of age, the premiums for only the three oldest covered children shall be taken into account in determining the total premium rate for such family.
(iii) Premium rates for employees and dependents for nongrandfathered plans shall be calculated for each covered individual and premium rates for the small employer group shall be calculated by totaling the premiums attributable to each covered individual.
(C) Premium rates for any given plan may vary by actuarially justified differences in plan design.

(D) For purposes of this subdivision, "grandfathered plan" has the same meaning as "grandfathered health plan" as provided in the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time.
(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.

[(11)**]** (3) No small employer carrier or producer shall, directly or indirectly, engage in the following activities: **[**(12)**]** (4) 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)**]** (5) 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)**]** (6) 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)**]** (7) 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)**]** (8) 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)**]** (9) Any violation of subdivisions **[**(10) to (16)**]** (3) to (7), inclusive, of this section and of any regulations established under subdivision **[**(17)**]** (8) 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.**]**

Sec. 15. Subparagraph (B) of subdivision (2) of section 38a-567 of the general statutes, as amended by section 7 of this act, is repealed and the following is substituted in lieu thereof (*Effective January 1, 2015*):

(B) (i) With respect to nongrandfathered plans issued to small employers, the premium rates charged or offered shall be established on the basis of a single pool of all nongrandfathered 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; **[**.**]**

(III) Tobacco use, except that such rate may not vary by a ratio of greater than 1.5 to 1.0 and may only be applied with respect to individuals who may legally use tobacco under state and federal law. For purposes of this subparagraph, "tobacco use" means the use of tobacco products four or more times per week on average within a period not longer than the six months immediately preceding. "Tobacco use" does not include the religious or ceremonial use of tobacco.

(ii) Total premium rates for family coverage for nongrandfathered plans shall be determined by adding the premiums for each individual family member, except that with respect to family members under twenty-one years of age, the premiums for only the three oldest covered children shall be taken into account in determining the total premium rate for such family.

(iii) Premium rates for employees and dependents for nongrandfathered plans shall be calculated for each covered individual and premium rates for the small employer group shall be calculated by totaling the premiums attributable to each covered individual.

(iv) Premium rates for any given nongrandfathered plan may vary by actuarially justified amounts to reflect the plan's provider network and administrative expense differences that can be reasonably allocated to such plan.

Sec. 16. 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, revision of 1958, revised to January 1, 2013. 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**]** On and after the effective date of this section, 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 <u>whose health insurance plan is subject to section 38a-567, as amended by this act,</u> may reinsure with the pool coverage of an eligible employee of a small employer **[**,**]** or any dependent of such an employee. **[**, 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**]** that 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**]** that 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**]** (d) (1) The participation in the pool as members, the establishment of rates, forms or procedures **[**nor**]** or any other joint or collective action required by this section shall not 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**]** this section, section 38a-564, as amended by this act, **[**to 38a-572, inclusive**]** 38a-566, as amended by this act, or 38a-567, as amended by this act, and such expenses shall be paid by the pool established in this section.

Sec. 17. Section 38a-574 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(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. Within**]** to determine whether to cede lives to the reinsurance pool. Not later than ninety days after approval by the Insurance Commissioner of the **[**standard underwriting form**]** family health statement, 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**]** statement may be amended from time to time as the board deems necessary, subject to the approval of the Insurance Commissioner.

Sec. 18. Subsection (f) of section 5-248a of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):
(f) **[**Notwithstanding the provisions of subsection (b) of section 38a-554, the**]** The state shall pay for the continuation of health insurance benefits for the employee during any leave of absence taken pursuant to this section. In order to continue any other health insurance coverages during such leave, the employee shall contribute that portion of the premium the employee would have been required to contribute had the employee remained an active employee during the leave period.
(i) The Comptroller may provide for coverage of employees of municipalities, nonprofit corporations, community action agencies and small employers and individuals eligible for a health coverage tax credit, retired members or members of an association for personal care assistants under the plan or plans procured under subsection (a) of this section, provided: (1) Participation by each municipality, nonprofit corporation, community action agency, small employer, eligible individual, retired member or association for personal care assistants shall be on a voluntary basis; (2) where an employee organization represents employees of a municipality, nonprofit corporation, community action agency or small employer, participation in a plan or plans to be procured under subsection (a) of this section shall be by mutual agreement of the municipality, nonprofit corporation, community action agency or small employer and the employee organization only and neither party may submit the issue of participation to binding arbitration except by mutual agreement if such binding arbitration is available; (3) no group of employees shall be refused entry into the plan by reason of past or future health care costs or claim experience; (4) rates paid by the state for its employees under subsection (a) of this section are not adversely affected by this subsection; (5) administrative costs to the plan or plans provided under this subsection shall not be paid by the state; (6) participation in the plan or plans in an amount determined by the state shall be for the duration of the period of the plan or plans, or for such other period as mutually agreed by the municipality, nonprofit corporation, community action agency, small employer, retired member or association for personal care assistants and the Comptroller; and (7) nothing in this section or section 12-202a, 38a-551, as amended by this act, **[**38a-553**]** or 38a-556, as amended by this act, shall be construed as requiring a participating insurer or health care center to issue individual policies to

individuals eligible for a health coverage tax credit. The coverage provided under this section may be referred to as the "Municipal Employee Health Insurance Plan". The Comptroller may arrange and procure for the employees and eligible individuals under this subsection health benefit plans that vary from the plan or plans procured under subsection (a) of this section. Notwithstanding any provision of part V of chapter 700c, the coverage provided under this subsection may be offered on either a fully underwritten or risk-pooled basis at the discretion of the Comptroller. For the purposes of this subsection, (A) "municipality" means any town, city, borough, school district, taxing district, fire district, district department of health, probate district, housing authority, regional work force development board established under section 31-3k, regional emergency telecommunications center, tourism district established under section 32-302, flood commission or authority established by special act, regional planning agency, transit district formed under chapter 103a, or the Children's Center established by number 571 of the public acts of 1969; (B) "nonprofit corporation" means (i) a nonprofit corporation organized under 26 USC 501 that has a contract with the state or receives a portion of its funding from a municipality, the state or the federal government, or (ii) an organization that is tax exempt pursuant to 26 USC 501(c)(5); (C) "community action agency" means a community action agency, as defined in section 17b-885; (D) "small employer" means a small employer, as defined in **[**subparagraph (A) of subdivision (4) of**]** section 38a-564, as amended by this act; (E) "eligible individuals" or "individuals eligible for a health coverage tax credit" means individuals who are eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, in accordance with the Pension Benefit Guaranty Corporation; **[**and Trade Adjustment Assistance programs of the Trade Act of 2002 (P.L. 107-210);**]** (F) "association for personal care assistants" means an organization composed of personal care attendants who are employed by recipients of service (i) under the home-care program for the elderly under section 17b-342, (ii) under the personal care assistance program under section 17b-605a,

Sec. 19. Subsection (i) of section 5-259 of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(iii) in an independent living center pursuant to sections 17b-613 to 17b-615, inclusive, or (iv) under the program for individuals with acquired brain injury as described in section 17b-260a; and (G) "retired members" means individuals eligible for a retirement benefit from the Connecticut municipal employees' retirement system. Sec. 15. Subsection (i) of section 5-259 of the 2014 supplement to the general statutes, as amended by section 266 of public act 13-247, is repealed and the following is substituted in lieu thereof (*Effective January 1, 2015*):

(i) The Comptroller may provide for coverage of employees of municipalities, nonprofit corporations, community action agencies and small employers and individuals eligible for a health coverage tax credit, retired members or members of an association for personal care assistants under the plan or plans procured under subsection (a) of this section, provided: (1) Participation by each municipality, nonprofit corporation, community action agency, small

employer, eligible individual, retired member or association for personal care assistants shall be on a voluntary basis; (2) where an employee organization represents employees of a municipality, nonprofit corporation, community action agency or small employer, participation in a plan or plans to be procured under subsection (a) of this section shall be by mutual agreement of the municipality, nonprofit corporation, community action agency or small employer and the employee organization only and neither party may submit the issue of participation to binding arbitration except by mutual agreement if such binding arbitration is available; (3) no group of employees shall be refused entry into the plan by reason of past or future health care costs or claim experience; (4) rates paid by the state for its employees under subsection (a) of this section are not adversely affected by this subsection; (5) administrative costs to the plan or plans provided under this subsection shall not be paid by the state; (6) participation in the plan or plans in an amount determined by the state shall be for the duration of the period of the plan or plans, or for such other period as mutually agreed by the municipality, nonprofit corporation, community action agency, small employer, retired member or association for personal care assistants and the Comptroller; and (7) nothing in this section or section 12-202a, 38a-551, as amended by this act, **[**38a-553**]** or 38a-556, as amended by this act, shall be construed as requiring a participating insurer or health care center to issue individual policies to individuals eligible for a health coverage tax credit. The coverage provided under this section may be referred to as the "Municipal Employee Health Insurance Plan". The Comptroller may arrange and procure for the employees and eligible individuals under this subsection health benefit plans that vary from the plan or plans procured under subsection (a) of this section. Notwithstanding any provision of part V of chapter 700c, the coverage provided under this subsection may be offered on either a fully underwritten or risk-pooled basis at the discretion of the Comptroller. For the purposes of this subsection, (A) "municipality" means any town, city, borough, school district, taxing district, fire district, district department of health, probate district, housing authority, regional work force development board established under section 31-3k, regional emergency telecommunications center, tourism district established under section 32-302, flood commission or authority established by special act, regional council of governments, transit district formed under chapter 103a, or the Children's Center established by number 571 of the public acts of 1969; (B) "nonprofit corporation" means (i) a nonprofit corporation organized under 26 USC 501 that has a contract with the state or receives a portion of its funding from a municipality, the state or the federal government, or (ii) an organization that is tax exempt pursuant to 26 USC 501(c)(5); (C) "community action agency" means a community action agency, as defined in section 17b-885; (D) "small employer" means a small employer, as defined in **[**subparagraph (A) of subdivision (4) of**]** section 38a-564, as amended by this act; (E) "eligible individuals" or "individuals eligible for a health coverage tax credit" means individuals who are eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time

to time amended, in accordance with the Pension Benefit Guaranty Corporation; **[**and Trade Adjustment Assistance programs of the Trade Act of 2002 (P. L. 107-210);**]** (F) "association for personal care assistants" means an organization composed of personal care attendants who are employed by recipients of service (i) under the home-care program for the elderly under section 17b-342, (ii) under the personal care assistance program under section 17b-605a, (iii) in an independent living center pursuant to sections 17b-613 to 17b-615, inclusive, or (iv) under the program for individuals with acquired brain injury as described in section 17b-260a; and (G) "retired members" means individuals eligible for a retirement benefit from the Connecticut municipal employees' retirement system.

Sec. 20. Subdivision (7) of section 12-201 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(7) "Gross direct premiums" means all receipts of premiums from policyholders and applicants for policies, whether received in the form of money or other valuable consideration, but excluding annuity premiums and considerations and premiums received for reinsurances assumed from other insurance companies; **[**and premiums received after July 1, 1990, and before January 1, 1995, for any special health care plan, as defined in section 38a-564;**]**

Sec. 21. Subsection (c) of section 12-211 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) The provisions of this section shall not apply to ad valorem taxes on real or personal property, personal income taxes, fees for agents' licenses, special purpose assessments imposed in connection with particular kinds of insurance including, but not limited to, workers' compensation assessments and Insurance Guaranty Association Fund assessments, or to premium taxes on special health care plans as defined in **[**section**]** sections 38a-564, revision of 1958, revised to January 1, 2013, and 38a-551, as amended by this act, except in the case where another state or foreign country imposes upon Connecticut domiciled insurers retaliatory charges for such taxes, fees or assessments.

Sec. 22. Section 12-212a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

All corporations organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, shall pay to the Commissioner of Revenue Services on or before March first, annually, a charge at the rate of two per cent of the total net direct subscriber charges **[**, excluding those net direct subscriber charges received after July 1, 1990, and before January 1, 1995, from employers for any special health care plan, as defined in section 38a-564,**]** received by such corporation during the next preceding calendar year, which shall be in addition to any other payment required under section 38a-48. The charge required under this section and any

other payment required under said section 38a-48 shall be in compensation for the costs and expenses of regulation by the Insurance Department and all other governmental services. The provisions of this chapter pertaining to the filing of returns, declarations, assessment and collection of taxes, and penalties imposed on domestic insurance companies shall apply with respect to the charge imposed under this section, provided corporations subject to the charge imposed under this section shall not be subject to any tax imposed under this chapter.

Sec. 23. Subsection (e) of section 17b-265 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(e) **[**Notwithstanding the provisions of subsection (c) of section 38a-553, no**]** No self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care plan, or any plan offered or administered by a health care center, pharmacy benefit manager, dental benefit manager, third-party administrator or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, shall contain any provision that has the effect of denying or limiting enrollment benefits or excluding coverage because services are rendered to an insured or beneficiary who is eligible for or who received medical assistance under this chapter. No insurer, as defined in section 38a-497a, shall impose requirements on the state Medicaid agency, which has been assigned the rights of an individual eligible for Medicaid and covered for health benefits from an insurer, that differ from requirements applicable to an agent or assignee of another individual so covered.

Sec. 24. Subsection (c) of section 17b-284 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) The commissioner may pay under the Medicaid program, within available appropriations, the premiums for continued health insurance coverage under an employer's group health insurance plan, pursuant to section **[**38a-554**]** 38a-512a, as amended by this act, for chronically ill and disabled persons who are no longer employed and would otherwise be eligible for Medicaid.

Sec. 25. Subdivision (6) of subsection (c) of section 17b-299 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(6) Expiration of the continuation of coverage periods set forth in section **[**38a-554**]** 38a-512a, as amended by this act;

Sec. 26. Subsection (b) of section 17b-611 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) The contract shall provide the same benefits as are provided under contracts issued pursuant to sections 38a-505, as amended by this act, 38a-546, 38a-551, as amended by this act, and 38a-556 to 38a559, inclusive, as amended by this act, except mental and nervous disorders shall be

covered in accordance with section 38a-514.

Sec. 27. Subsection (b) of section 19a-7b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) The commission shall develop the design, administrative, actuarial and financing details of program initiatives necessary to attain the goal described in section 19a-7a. **[**The commission shall study the experience of the state under the programs and policies developed pursuant to sections 12201, 12-211, 12-212a, 17b-277, 17b-282 to 17b-284, inclusive, 17b-611, 19a-7a to 19a-7d, inclusive, subsection (a) of 19a-59b, subsection (b) of section 38a-552, subsection (d) of section 38a-556 and sections 38a-564 to 38a-573, inclusive, and shall make interim reports to the General Assembly on its findings by January 15, 1991, and by February 1, 1992, and a final report on such findings by February 1, 1993.**]** The commission shall make recommendations to the General Assembly on any legislation necessary to further the attainment of the goal described in section 19a-7a.

Sec. 28. Subsection (a) of section 31-51o of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Whenever a relocation or closing of a covered establishment occurs, the employer of the covered establishment shall pay in full for the continuation of existing group health insurance, no matter where the group policy was written, issued or delivered, for each affected employee and his dependents, if covered under the group policy, from the date of relocation or closing for a period of one hundred twenty days or until such time as the employee becomes eligible for other group coverage, whichever is the lesser, provided any right of such employee and his dependents to a continuation of coverage, as required by section **[**38a-538 or 38a-554**]** 38a-512a, as amended by this act, shall not be affected by the provisions of this section, and provided further the period of continued coverage required by said sections shall not commence until the period of continued coverage established by this section has terminated.

Sec. 29. Section 38a-472d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Not later than January 1, 2006, the Insurance Commissioner, in consultation with the Commissioner of Social Services and the Healthcare Advocate, shall develop a comprehensive public education outreach program to educate health insurance consumers about the availability and general eligibility requirements of various health insurance options in this state. The program shall maximize public information concerning health insurance options in this state and shall provide for the dissemination of such information on the Insurance Department's Internet web site.

(b) The information on the department's Internet web site shall reference the availability and general eligibility requirements of (1) programs administered by the Department of Social Services, including, but not limited to, the Medicaid program and the HUSKY Plan, Part A and Part B, (2) health insurance coverage provided by the Comptroller under subsection (i) of section

5-259, as amended by this act, **[**(3) health insurance coverage available under comprehensive health care plans issued pursuant to part IV of this chapter, and (4)**]** and (3) other health insurance coverage offered through local, state or federal agencies or through entities licensed in this state. The commissioner shall update the information on the web site at least quarterly.

Sec. 30. Section 38a-505 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

In order to provide reasonable simplification of terms and coverages of individual health insurance policies, to facilitate public understanding and comparison, to eliminate provisions **[**which**]** that may be misleading or unreasonably confusing in connection with either the purchase of such coverage or with the settlement of claims and to provide for full disclosure in the sale of such coverages:

[(a)**]** (1) The commissioner shall **[**issue**]** adopt regulations, in accordance with the provisions of chapter 54, to establish specific standards for policy provisions used in individual health insurance policies, **[**but not including group conversion policies, which**]** that shall be in addition to and in accordance with sections 38a-80, 38a-321 to 38a-324, inclusive, 38a-326, 38a-329, 38a-334 to 38a-336a, inclusive, 38a-338 to 38a-358, inclusive, 38a-470 to 38a-472, inclusive, 38a-475, 38a-480 to 38a-503, inclusive, 38a-507, 38a-514, 38a-519, 38a-523, 38a-531, 38a-577 to 38a-590, inclusive, and 38a-802 to 38a810, inclusive, and other applicable laws of this state **[**which**]** that may cover the terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, termination of insurance, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacements, recurrent conditions, preexisting conditions **[**,**]** and the definition of the terms hospital, accident, sickness, injury, physician, accidental means, total disability, permanent disability, partial disability, nervous disorders, guaranteed renewable **[**,**]** and noncancellable.

[(b)**]** (2) The commissioner shall adopt regulations, in accordance with chapter 54, that specify prohibited policy provisions not otherwise specifically authorized by statute **[**which**]** that, in the opinion of the commissioner, are unjust, unfair or unfairly discriminatory to the policyholder, any person insured under the policy **[**,**]** or any beneficiary.

[(c)**]** (3) The commissioner shall adopt regulations, in accordance with chapter 54, to establish minimum standards for benefits under each of the following categories of coverage in individual policies: **[**, other than conversion policies issued pursuant to a contractual conversion privilege under a group policy:**]** Basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage and specified

disease coverage.

[(d)**]** (4) Nothing in this section shall preclude the issuance of any policy **[**which**]** that combines two or more of the categories of coverage enumerated in **[**subsection (c)**]** subdivision (3) of this section, except that specified accident coverage shall not be combined with any other category of coverage. The commissioner shall prescribe the method of identification of policies based upon coverage provided.

[(e)**]** (5) No policy shall be delivered or issued for delivery in this state **[**which**]** that does not meet the prescribed minimum standards for the categories of coverage listed in **[**subsection (c)**]** subdivision (3) of this section, provided nothing in this section shall preclude the issuance or delivery of any policy **[**which**]** that does not meet such prescribed minimum standards of coverage so long as such policy is clearly identified as not meeting such prescribed standards.

[(f)**]** (6) No such policy shall be delivered in this state unless: **[**(1)**]** (A) An outline of coverage described herein accompanies the policy or **[**(2)**]** (B) the outline of coverage described in this section is delivered to the applicant at the time application is made and acknowledgment of receipt of certificate of delivery of such outline is provided the carrier with the application. In the event the policy is issued on a basis other than that applied for, the outline of coverage properly describing the policy shall accompany the policy when it is delivered. The outline of coverage shall include: **[**(A)**]** (i) A statement identifying the applicable category or categories of coverage provided by the policy in accordance with this section; **[**(B)**]** (ii) a description of the principal benefits and coverage provided in the policy; **[**(C)**]** (iii) a statement of the exceptions, reductions and limitations contained in the policy or contract; **[**(D)**]** (iv) a statement of the renewal provisions including any reservation by the carrier of a right to change premiums; and **[**(E)**]** (v) a statement that the outline is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

[(g) Notwithstanding the provisions of sections 38a-80, 38a-321 to 38a-324, inclusive, 38a-326, 38a-329, 38a-334 to 38a-336a, inclusive, 38a-338 to 38a-358, inclusive, 38a-470 to 38a-472, inclusive, 38a-475, 38a480 to 38a-503, inclusive, 38a-507, 38a-514, 38a-519, 38a-523, 38a-531, 38a-577 to 38a-590, inclusive, and 38a-802 to 38a-810, inclusive, if a carrier elects to use a simplified application form, with or without any questions as to the applicant's health at the time of application, but without any questions concerning the insured's health history or medical treatment history, the policy shall cover loss developing after twelve months from any preexisting condition not specifically excluded from coverage by the terms of the policy and, except as so provided, the policy shall not include wording that would permit a defense based upon preexisting conditions.**]**

[(h)**]** (7) Regulations promulgated pursuant to this section shall specify an effective date applicable to policy and benefit riders delivered or issued for delivery in this state on and after such effective date **[**which**]** that shall not be less than one hundred eighty days after the date of adoption or promulgation.

Sec. 31. Section 38a-573 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

If any provision of **[**sections**]** section 38a-564, as amended by this act, **[**to 38a-572, inclusive**]** 38a-566, as amended by this act, 38a-567, as amended by this act, or 38a-569, as amended by this act, is held invalid, the invalidity shall not affect other provisions of said sections **[**which**]**

that can be given effect without the invalid provisions.

Sec. 32. Section 38a-543 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

[No individual, partnership, corporation or unincorporated association which employs less than twenty employees and provides group hospital, surgical or medical insurance coverage for its employees may reduce the coverage provided to any employee or any employee's spouse solely because he has reached the age of sixty-five and is eligible for Medicare benefits except to the extent such coverage is provided by Medicare. The terms of any such plan provided by any such employer which employs twenty or more employees shall entitle any employee who has attained the age of sixty-five and any employee's spouse who has attained the age of sixty-five to group hospital, surgical or medical insurance coverage under the same conditions as any covered employee or spouse who is under the age of sixty-five.**]** No group health insurance policy delivered, issued for delivery, renewed, amended or continued in this state shall include any provision that reduces payments on the basis that an individual is eligible for Medicare by reason of age, disability or end-stage renal disease, unless such individual enrolls in Medicare. If such individual enrolls in Medicare, any such reduction shall be only to the extent such coverage is provided by Medicare.

Sec. 33. Sections 38a-553 to 38a-555, inclusive, 38a-565, 38a-568 and 38a-570 to 38a-572, inclusive, of the general statutes are repealed. (*Effective from passage*)

Sec.34. Section 38a-538 of the 2014 supplement to the general statutes is repealed. (*Effective from passage*)

Sec.35 (NEW) No individual health insurance policy delivered, issued for delivery, renewed, amended or continued in this state shall include any provision that reduces payments on the basis

that an individual is eligible for Medicare by reason of age, disability or end-stage renal disease, unless such individual enrolls in Medicare. If such individual enrolls in Medicare, any such reduction shall be only to the extent such coverage is provided by Medicare.