Agency Legislative Proposal - 2016 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: CID
Liaison: Commissioner Wade Phone: 860-297-3801 E-mail: Katharine.Wade@ct.gov
Lead agency division requesting this proposal:
Agency Analyst/Drafter of Proposal: Jon Arsenault

Title of Proposal **An Act Authorizing Multistate HMOs in Connecticut**
Statutory Reference **New provisions added to supplement 38a-43, 38a-175 to 38a-194, and Section 6.**
Proposal Summary **To enable health care centers to operate across state lines and to create regional reciprocity licensing agreements for 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? N**o***

(2) *Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?* ***Yes – a number of states such as Pennsylvania, Maryland, Rhode Island, Maine Georgia and Washington have adopted legislation to permit health care centers (aka HMOs) to operate across state lines. As a result, more health care centers are consolidating under those states.***

(3) *Have certain constituencies called for this action?* ***Yes – this permits more choice and flexibility, creates efficiencies for the health care centers (aka HMOs), and permits Connecticut domiciled health care centers to grow and expand.***

(4) *What would happen if this was not enacted in law this session?* ***Some companies in consolidating HMOs established in various states, may continue to consolidate the legal entities into a non-Connecticut domestic legal entity.***

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

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

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

PROPOSAL IMPACT

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

Agency Name: **No other agencies are affected by this legislation.**
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

Could impact resource need in CID but would likely be offset by assessment revenue

Federal

N/A

Additional notes on fiscal impact

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

Sec. 1 – Makes a technical change to Conn. Gen. Stat. § 38a-43 to reference "domestic health care center".

Sec. 2 – Conn. Gen. Stat. § 38a-175 definitions related to health care centers are amended to include foreign health care centers.

Sec. 3 – Conn. Gen. Stat. § 38a-178 is amended to establish reciprocity without licensing for contiguous border health care centers for up to 500 enrollees from Connecticut.

Sec. 4 – Conn. Gen. Stat. § 38a-183 is amended to include foreign health care centers under the Commissioner's authority for prior rate review and approval.

Sec. 5 - Conn. Gen. Stat. § 38a-194(d) is amended to clarify that in the event of the insolvency of a health care center, this provision governing the priority of distribution of the general assets of the health care center is applicable to domestic health care centers.

Sec. 6 –A new provision is enacted permitting foreign health care centers to be licensed in Connecticut (using Pennsylvania statute as model – 40 P.S. §1556.1).

- (a) provides for health care centers licensed in another state may be authorized in CT by evidencing it is licensed in another state and meets the CT requirements for health care centers organized in CT
- (b) provides for the Commissioner to waive CT requirements if the CT requirement is not appropriate, in the Commissioner's determination , to the foreign health care center and that the waiver will still cause the health care center to operate consistent with CT purposes and provisions and will not create unfair discrimination in favor of the foreign health care center
- (c) provides that the Commissioner is authorized and directed to enter into reciprocal agreements with other states permitting the Commissioner to accept audits, exams and other reviews of foreign health care centers to assist in determining if those health care centers meet CT licensing requirements
- (d) authorizes the Commissioner to suspend or revoke a foreign health care center's license to operate if minimum net worth falls below the CT statutory requirements of 38a-193.
- (e) provides the Commissioner authority to promulgate regulations.

An Act Authorizing Multistate HMOs in Connecticut

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

Section 1. Section 38a-43 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2016*):

Whenever it appears to the commissioner that permission to transact business within any state of the United States or within any foreign country has been refused to any domestic insurance company or domestic health care center after a certificate of the solvency and good management of such company has been issued to it by the commissioner and after such company has complied with any reasonable laws of such state or foreign country requiring deposits of money or securities with the government of such state or country, the commissioner may immediately cancel the authority of each company organized under the laws of such state or foreign government and licensed to do business in this state and may refuse a certificate of authority to each such company thereafter applying for authority to do business in this state, until the commissioner's certificate has been recognized by the government of such state or country.

Sec. 2. Section 38a-175 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2016*):

As used in sections 38a-175 to 38a-194 and Section 6 of this Act:

(1) "Healing arts" means the professions and occupations licensed under the provisions of chapters 370, 372, 373, 375, 378, 379, 380, 381 and 383.

(2) "Carrier" means a health care center, insurer, hospital service corporation, medical service corporation or other entity responsible for the payment of benefits or provision of services under a group contract.

(3) "Commissioner" means the Insurance Commissioner, except when explicitly stated otherwise.

(4) "Evidence of coverage" means a statement of essential features and services of the health care center coverage which is given to the subscriber by the health care center or by the group contract holder.

(5) “Federal Health Maintenance Organization Act” means Title XIII of the Public Health Service Act, 42 USC Subchapter XI, as from time to time amended, or any successor thereto relating to qualified health maintenance organizations.

(6) “Foreign health care center” means a health care center formed under the laws of the United States, of a state or territory of the United States other than this state, or of the District of Columbia.

(7)“Group contract” means a contract for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

[(7)](8) “Group contract holder” means the person to which a group contract has been issued.

[(8)](9) “Health care” includes, but shall not be limited to, the following: Medical, surgical and dental care provided through licensed practitioners, including any supporting and ancillary personnel, services and supplies; physical therapy service provided through licensed physical therapists upon the prescription of a physician; psychological examinations provided by registered psychologists; optometric service provided by licensed optometrists; hospital service, both inpatient and outpatient; convalescent institution care and nursing home care; nursing service provided by a registered nurse or by a licensed practical nurse; home care service of all types required for the health of a person; rehabilitation service required or desirable for the health of a person; preventive medical services of all and any types; furnishing necessary appliances, drugs, medicines and supplies; educational services for the health and well-being of a person; ambulance service; and any other care, service or treatment related to the prevention or treatment of disease, the correction of defects and the maintenance of the physical and mental well-being of human beings. Any diagnosis and treatment of diseases of human beings required for health care as defined in this section, if rendered, shall be under the supervision and control of the providers.

[(9)](10) “Health care center” means either: (A) A person, including a profit or a nonprofit corporation organized under the laws of the United States, this state, another state or the District of Columbia for the purpose of carrying out the activities and purposes set forth in subsection (b) of section 38a-176, at the expense of the health care center, including the providing of health care, as herein defined, to members of the community, including subscribers to one or more plans under an agreement entitling such subscribers to health care in consideration of a basic advance or periodic charge and shall include a health maintenance organization, or (B) a line of business conducted by an organization that is formed, pursuant to the laws of this state for the purposes of, but

not limited to, carrying out the activities and purposes set forth in subsection (b) of section 38a-176.

[(10)](11) “Individual contract” means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the subscriber.

[(11)](12) “Individual practice association” means a partnership, corporation, association, or other legal entity which has entered into a services arrangement with health care professionals licensed in this state to provide services to enrollees of a health care center.

[(12)](13) “Insolvent” or “insolvency” means that the organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction.

[(13)] (14)“Net worth” means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt as defined in section 38a-193.

[(14)](15) “Member” or “enrollee” means an individual who is enrolled in a health care center.

[(15)](16) “Person” means an individual, corporation, limited liability company, partnership, association, trust or any other legal entity.

[(16)](17) “Uncovered expenditures” means the cost of health care services that are covered by a health care center, for which an enrollee would also be liable in the event of the center’s insolvency, and for which no alternative arrangements have been made that are acceptable to the commissioner. Uncovered expenditures shall not include expenditures for services when a provider has agreed not to bill the enrollee even though the provider is not paid by the health care center or for services that are guaranteed, insured or assumed by a person other than the health care center.

[(17)](18) “Enrolled population” means a group of persons, defined as to probable age, sex and family composition, which receives health care from a health care center in consideration of a basic advance or periodic charge.

[(18)](19) “Participating provider” means a provider who, under an express or implied contract with the health care center or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health care center.

[(19)](20) “Provider” means any licensed health care professional or facility, including individual practice associations.

(21) “Subscriber” means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health care center, or in the case of an individual contract, the person in whose name the contract is issued.

Sec. 3. Section 38a-178 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2016*):

Persons desiring to form a health care center may organize under the general law of the state governing corporations, partnerships, associations or trusts, but subject to the following provisions: (1) The certificate of incorporation or other organizational document of each such organization shall have endorsed thereon or attached thereto the consent of the commissioner if he finds the same to be in accordance with the provisions of sections 38a-175 to 38a-192, inclusive, and section 6 of this act; and (2) the certificate or other document shall include a statement of the area in which the health care center will operate and the services to be rendered by such organization. Notwithstanding any other provision of this title, no license shall be required of a health care center duly licensed in a state contiguous to this state that contracts on a limited basis with health care providers in this state for the provision of health care services to enrollees under a group contract neither delivered nor issued for delivery in this state, provided that the number of Connecticut residents receiving such health care services shall not exceed 500 enrollees of such health care center; and the contracts with such providers shall contain a hold harmless clause that is not less favorable in any respect to any enrollee that is a Connecticut resident than the hold harmless provisions as set forth in subsection (c) of section 38a-193.

Sec. 4. Section 38a-183 of the general statutes as amended by section 1 of Public Act 15-247 is repealed and the following is substituted in lieu thereof (*Effective July 1, 2016*):

(a) (1) A health care center, including ~~a~~ foreign health care center, governed by sections 38a-175 to 38a-192, inclusive, and sections 5 and 6 of this act, 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. Such filing shall include an actuarial memorandum that includes, but is not limited to, pricing assumptions and claims experience, and premium rates and loss ratios from the inception of the contract or policy. The

commissioner may refuse such approval if the commissioner finds such amounts to be excessive, inadequate or discriminatory. As used in this subsection, "loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations.

(2) Premium rates offered to individuals shall be consistent with the requirements set forth in section 38a-481, as amended by this act.

(3) Premium rates offered to small employers, as defined in section 38a-564, as amended by this act, shall be consistent with the requirements set forth in section 38a-567, as amended by this act.

(4) No such health care center, including a foreign health care center authorized to do business in this state pursuant to section 6 of this act, shall 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 the commissioner's approval or disapproval thereof.

Sec. 5. Section 38a-194(d) of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2016*):

(d) Insolvency. Priority of distribution. In the event of the insolvency of a domestic health care center, for purposes of determining the priority of distribution of the general assets of the health care center, claims of enrollees, enrollees' beneficiaries, subscribers and subscribers' beneficiaries shall have the same priority as established by section 38a-944 for policyholders and beneficiaries of insureds of insurance companies described in subdivision (3) of subsection (a) of section 38a-944. If an enrollee or subscriber is liable to any provider for services provided pursuant to and covered by the health care center, that liability shall have the status of an enrollee or subscriber claim for distribution of assets. Any provider who is obligated by statute or agreement to hold enrollees or subscribers harmless from liability for services provided pursuant to and covered by a health care center shall have a priority of distribution of the general assets immediately following that of enrollees, enrollees' beneficiaries, subscribers and subscribers' beneficiaries as described in this subsection, and immediately preceding the priority of distribution described in subdivision (4) of subsection (a) of section 38a-944.

Sec. 6. (New) (*Effective July 1, 2016*): (a) A foreign health care center approved and regulated under the laws of another state may be authorized by issuance of a certificate of authority to operate or do business in this state by satisfying the Commissioner that it is fully and legally organized under the laws of its state, and that it complies with all requirements for health care centers organized within this state.

(b) The Commissioner may waive or modify the provisions of this title under which the Commissioner has the authority to act if the Commissioner determines that the same are not appropriate to a particular foreign health care center of another state, that such waiver or modification will be consistent with the purposes and provisions of this title, and that it will not result in unfair discrimination in favor of the health care center of another state.

(c) The Commissioner is hereby authorized and directed to develop with other states reciprocal licensing agreements concerning the licensure of health care centers which permit the commissioner to accept audits, inspections and reviews of agencies from other states to determine whether health care center licensed in other states meet the requirements of this state.

(d) If the minimum net worth of a foreign health care center falls below the minimum net worth required by section 38a-193, the Commissioner shall, consistent with said section, suspend or revoke the foreign health care center's license as being hazardous to its subscribers, enrollees, or the people in this state.

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

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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: CID
Liaison: Commissioner Wade Phone: 860-297-3801 E-mail: Katharine.Wade@ct.gov
Lead agency division requesting this proposal: Financial Regulation Division (§§1-7) Captives insurance Division (§§8-14)
Agency Analyst/Drafter of Proposal: Jon Arsenault

Title of Proposal

AAC INSURER CORPORATE GOVERNANCE ANNUAL DISCLOSURE, RISK RETENTION GROUPS, AND HYPOTHECATION OF ASSETS BY CAPTIVE INSURERS,

Statutory Reference: Conn. Gen. Stat. §§ 38a-55, 38a-250 to 38a-253, inclusive, 38a-255.

Proposal Summary

This proposal has three main parts: **(1)** adoption of the National Association of Insurance Commissioners Corporate Governance Annual Disclosure Model Act which enhances the Insurance Commissioner's regulatory oversight of domestic insurers and insurer groups by obtaining critical information regarding corporate governance activities; **(2)** amendments to existing statutes concerning risk retention groups to closely track with the NAIC Model Risk Retention Act; and **(3)** to exempt domestic captive insurers from the provisions of Conn. Gen. Stat. § 38a-55 concerning hypothecation of assets.

Corporate Governance

Sec. 1 (NEW) recites the purpose of Sections 1 to 7, inclusive, concerning corporate governance annual disclosure, and contains definitions.

Sec. 2 (NEW) contains the annual disclosure and filing requirements.

Sec. 3 (NEW) specifies the contents of the annual corporate governance disclosure.

Sec. 4 (NEW) provides for the confidentiality of corporate governance information to be disclosed.

Sec. 5 (NEW) authorizes the Commissioner to retain, at the insurer's expense, third-party consultants, including attorneys, actuaries, accountants and other experts not otherwise a part of the Commissioner's staff as may be reasonably necessary to assist in reviewing the corporate governance annual disclosure and related information or the insurer's compliance with this Act.

Sec. 6 (NEW) imposes a $175 per day penalty for failure to file the corporate governance annual disclosure statement with the Commissioner.

Sec. 7 (NEW) adds a severability clause.

Risk Retention Groups

Sec. 8 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. 9 amends Conn. Gen. Stat. § 38a-250 to add a definition of "NAIC".

Sec. 10 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. 11 amends Conn. Gen. Stat. § 38a-252 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. 12 makes minor changes to Conn. Gen. Stat. § 38a-253 concerning submission of information to the Commissioner from RRGs domiciled outside Connecticut.

Sec. 13 makes a minor change to Conn. Gen. Stat. § 38a-255 to require in addition to every policy, that every application form for insurance from a risk retention group shall contain a notice that the risk retention group may not be subject to all the insurance laws and that the insurance guaranty association funds are not available for the risk retention group.

Captive Insurers

Sec. 14 amends Conn. Gen. Stat. § 38a-91oo concerning applicability of insurance statutes to captive insurers to delete the reference to Gen. Stat. § 38a-55 concerning hypothecation of assets of domestic insurers.

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

PROPOSAL BACKGROUND

Reason for Proposal: (1) Adoption of the NAIC Corporate Governance Annual Disclosure Model Act responds to the need to the broad regulatory need to have a better understanding of insurers' governance practices and to facilitate the review and assessment of this information through the solvency-monitoring process. Adoption of such model will serve to bring about increase consistency and compliance with international standards, and is expected to become a requirement for NAIC Accreditation at a later date.

(2) 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. Last 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 10(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.

(3) Removing the reference to Conn. Gen. Stat. Sec. 38a-55 frees captive applicants from limitations on their secured borrowing. This will allow more entities to consider domesticating their captives in Connecticut. Conn. Gen. Stat. Sec. 38a-55 contains language that empowers the Insurance Commissioner to consent to such secured borrowing, effectively overriding the prohibition in the statute should the Insurance Commissioner see fit. Only a small number of states have a prescribed limitation on pledged or hypothecated assets.

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)***? (1) Legislation concerning corporate governance is being implemented in all states and will likely be a requirement of the NAIC accreditation program; (2) legislation concerning risk retention groups has already been enacted throughout by states; (3) not many states have a statute similar to Conn. Gen. Stat. § 38a-55 and thus exempting domestic captive insurers from the statute concerning hypothecation of assets will place domestic captive insurers on par with those of most other states.**

(3) Have certain constituencies called for this action? **The members of the NAIC concerning parts (1) and (2).**

(4) What would happen if this was not enacted in law this session? **The Insurance Department would seek legislation in**

the following session.

- **Origin of Proposal** **_X__ New Proposal Parts (1) & (3)** **_X__ Resubmission Part (2)**

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? **SB 1026, AAC Risk Retention Groups passed the Senate but died on the House calendar in 2015.**

(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? **The CID.**

(4) What was the last action taken during the past legislative session? **Favorable Report, Tabled for the House Calendar, May 22, 2015.**

PROPOSAL IMPACT

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

Agency Name: **No other agencies impacted.**
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) **No fiscal impact.**

n/a

State
Sections 1 to 7 could require additional staffing in Financial Regulation. No other fiscal impact.

Federal
No fiscal impact.

Additional notes on fiscal impact

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

AN ACT CONCERNING INSURER CORPORATE GOVERNANCE ANNUAL DISCLOSURE

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

Section 1. (NEW) *(Effective January 1, 2017)* (a) It shall be the purpose of this Act to provide the Commissioner a summary of an insurer or insurance group's corporate governance structure, policies and practices to permit the Commissioner to gain and maintain an understanding of the insurer's corporate governance framework, to outline the requirements for completing a corporate governance annual disclosure with the Commissioner, to set forth the procedures for filing and the required contents of the corporate governance annual disclosure, and provide for the confidential treatment of the corporate governance annual disclosure and related information that will contain confidential and sensitive information related to an insurer or insurance group's internal operations and proprietary and trade secret information which, if made public, could potentially cause the insurer or insurance group competitive harm or disadvantage.

(b) Nothing in this act shall be construed to prescribe or impose corporate governance standards and internal procedures beyond that which is required under applicable state corporate law. Notwithstanding the foregoing, nothing in this act shall be construed to limit the Commissioner's authority, or the rights or obligations of third parties, under sections 38a-14 or 38a- 14a of the general statutes.

(c) The requirements of this Act shall apply to all insurers, fraternal benefit societies and health care centers domiciled in this state.

(d) As used in this Act, the following terms shall have the respective meanings hereinafter set forth, unless the context shall otherwise require:

(1) "Board" means the Board of Directors of the insurer or insurer group.

(2) "Commissioner" means the Insurance Commissioner;

(3) "CGAD" means a Corporate Governance Annual Disclosure shall mean a confidential report filed by the insurer or insurance group made in accordance with the requirements of this Act;

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

(5) “Insurance company” or “insurer” has the same meaning as provided in section 38a-1, except that it shall include a fraternal benefit society and health care center, but shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state;

(6) “NAIC” means the National Association of Insurance Commissioners;

(7) “ORSA Summary Report” means the report filed in accordance with section 38a-142 of the general statutes.

(8) “Senior Management” means any corporate officer responsible for reporting information to the board of directors at regular intervals or providing this information to shareholders or regulators and shall include, for example and without limitation, the Chief Executive Officer (“CEO”), Chief Financial Officer (“CFO”), Chief Operations Officer (“COO”), Chief Procurement Officer (“CPO”), Chief Legal Officer (“CLO”), Chief Information Officer (“CIO”), Chief Technology Officer (“CTO”), Chief Revenue Officer (“CRO”), Chief Visionary Officer (“CVO”), or any other “C” level executive.

Sec. 2. (NEW) *(Effective January 1, 2017)* (a) An insurer, or the insurance group of which the insurer is a member, shall, no later than June 1 of each calendar year, submit to the Commissioner a Corporate Governance Annual Disclosure (CGAD) that contains the information described in Section (3)(b) of this Act. Notwithstanding any request from the Commissioner made pursuant to subsection (c) of this section, if the insurer is a member of an insurance group, the insurer shall submit the report required by this section to the Commissioner of the 0 state for the insurance group, in accordance with the laws of the lead state, as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC. In these instances, a copy of the CGAD shall also be provided to the chief insurance regulatory official of any state in which the insurance group has a domestic insurer, upon request of such official.

(b) The CGAD must include a signature of the insurer or insurance group’s chief executive officer or corporate secretary attesting to the best of that individual’s belief and knowledge that the insurer has implemented the corporate governance practices and that a copy of the disclosure has been provided to the insurer’s board of directors or the appropriate committee thereof.

(c) An insurer not required to submit a CGAD under this section shall do so upon the Commissioner’s request.

(d) For purposes of completing the CGAD, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, depending upon how

the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

(e) The review of the CGAD and any additional requests for information shall be made through the lead state as determined by the procedures within the most recent NAIC Financial Analysis Handbook.

(f) An insurer or insurance group may comply with this section by referencing other existing documents (e.g., ORSA Summary Report, Holding Company Form B or F Filings, Securities and Exchange Commission (SEC) Proxy Statements, foreign regulatory reporting requirements, etc.) if the documents provide information that is comparable to the information described in section 3 of this Act. The insurer or insurance group shall clearly reference the location of the relevant information within the CGAD and attach the referenced document if it is not already filed or available to the regulator.

(g) Each year following the initial filing of the CGAD, the insurer or insurance group shall file an amended version of the previously filed CGAD indicating where changes have been made. If no changes were made in the information or activities reported by the insurer or insurance group, the filing should so state.

Sec. 3. (NEW) *(Effective January 1, 2017)* (a) The insurer or insurance group shall have discretion over the responses to the CGAD inquiries, provided the CGAD shall contain the material information necessary to permit the Commissioner to gain an understanding of the insurer's or group's corporate governance structure, policies, and practices. The Commissioner may request additional information that he or she deems material and necessary to provide the Commissioner with a clear understanding of the corporate governance policies, the reporting or information system or controls implementing those policies.

(b) Notwithstanding subsection (a) of this section, the CGAD shall be prepared consistent with this section. Documentation and supporting information shall be maintained and made available upon examination or upon request of the Commissioner.

(c) The insurer or insurance group shall be as descriptive as possible in completing the CGAD, with inclusion of attachments or example documents that are used in the governance process, since these may provide a means to demonstrate the strengths of their governance framework and practices.

(d) The CGAD shall describe the insurer's or insurance group's corporate governance framework and structure including consideration of the following: (1) the Board and various committees thereof ultimately responsible for overseeing the insurer or insurance group and the level(s) at which that oversight occurs (e.g., ultimate control level, intermediate holding company, legal entity, etc.). The insurer or insurance group shall describe and discuss the rationale for the current Board size and structure; and (2) the duties of the Board and each of its significant committees and how they are governed (e.g., bylaws, charters, informal mandates, etc.), as well as how the Board's leadership is structured, including a discussion of the roles of Chief Executive Officer (CEO) and Chairman of the Board within the organization.

(e) The insurer or insurance group shall describe the policies and practices of the most senior governing entity and significant committees thereof, including a discussion of the following factors:

(1) How the qualifications, expertise and experience of each Board member meet the needs of the insurer or insurance group;

(2) How an appropriate amount of independence is maintained on the Board and its significant committees;

(3) The number of meetings held by the Board and its significant committees over the past year as well as information on director attendance; and,

(4) How the insurer or insurance group identifies, nominates and elects members to the Board and its committees. The discussion should include, for example:

(A) Whether a nomination committee is in place to identify and select individuals for consideration;

(B) Whether term limits are placed on directors;

(C) How the election and re-election processes function; and,

(D) Whether a Board diversity policy is in place and if so, how it functions.

(5) The processes in place for the Board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance (including any Board or committee training programs that have been put in place).

(f) The insurer or insurance group shall describe the policies and practices for directing Senior Management, including a description of the following factors:

(1) Any processes or practices, such as suitability standards, to determine whether officers and key persons in control functions have the appropriate background, experience and integrity to fulfill their prospective roles, including:

(A) Identification of the specific positions for which suitability standards have been developed and a description of the standards employed; and,

(B) Any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate such changes.

(2) The insurer's or insurance group's code of business conduct and ethics, the discussion of which considers, for example:

(A) compliance with laws, rules, and regulations; and

(B) proactive reporting of any illegal or unethical behavior.

(3) The insurer's or insurance group's processes for performance evaluation, compensation and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description shall include sufficient detail to allow the Commissioner to understand how the organization ensures that compensation programs do not encourage and/or reward excessive risk taking. Elements to be discussed may include, for example:

(a) The Board's role in overseeing management compensation programs and practices.

(b) The various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid;

(c) How compensation programs are related to both company and individual performance over time;

(d) Whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels;

(e) Any clawback provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted;

(f) Any other factors relevant in understanding how the insurer or insurance group monitors its compensation policies to determine whether its risk management objectives are met by incentivizing its employees.

(4) The insurer's or insurance group's plans for CEO and Senior Management succession.

(g) The insurer or insurance group shall describe the processes by which the Board, its committees and Senior Management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's business activities, including a discussion of:

(1) How oversight and management responsibilities are delegated between the Board, its committees and Senior Management;

(2) How the Board is kept informed of the insurer's strategic plans, the associated risks, and steps that Senior Management is taking to monitor and manage those risks; and,

(3) How reporting responsibilities are organized for each critical risk area. The description should allow the Commissioner to understand the frequency at which information on each critical risk area is reported to and reviewed by Senior Management and the Board. This description may include, for example, the following critical risk areas of the insurer: (A) Risk management processes. An ORSA Summary Report filer may refer to its ORSA Summary Report pursuant to the Risk Management and Own Risk and Solvency Assessment Model Act; (B) Actuarial function; (C) Investment decision-making processes; (D) Reinsurance decision-making processes; (E) Business strategy/finance decision-making processes; (F) Compliance function; (G) Financial reporting/internal auditing; and (H) Market conduct decision-making processes.

Sec. 4. (NEW) *(Effective January 1, 2017)* (a) Documents, materials or other information including the CGAD, in the possession or control of the Insurance Department that are obtained by or disclosed to the Commissioner or any other person under this Act, are recognized by this state as being proprietary and to contain trade secrets. All such documents, materials or other information shall be confidential by law and privileged, shall not be subject to disclosure under section 1-210, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any civil action in this state. However, the Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties. The Commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer. Nothing in this section shall be construed to require written consent of the insurer before the Commissioner may share or receive confidential documents, materials or other CGAD-related information pursuant to subsection (c) of this section to assist in the performance of the Commissioner's regular duties.

(b) Neither the Commissioner nor any person who received documents, materials or other CGAD-related information, through examination or otherwise, while acting under the authority of the Commissioner, or with whom such documents, materials or other information are shared pursuant to this Act shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (a) of this section.

(c) In order to assist in the performance of the Commissioner's regulatory duties, the Commissioner: (1) May, upon request, share documents, materials or other CGAD-related information including the confidential and privileged documents, materials or information subject to subsection (a) of this section, including proprietary and trade secret documents and materials with other state, federal and international financial regulatory agencies, including members of any supervisory college as described in section 38a-135 of the general statutes, with the NAIC, and with third party consultants pursuant to section 5 of this Act, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, material or other information and has verified in writing the legal authority to maintain confidentiality; and (2) May receive documents, materials or other CGAD-related information, including otherwise confidential and privileged documents, materials or information, including proprietary and trade-secret information or documents, from regulatory officials of other state, federal and international financial regulatory agencies, including members of any supervisory college as described in section 38a-135 of the general statutes, and from the NAIC, and shall maintain as confidential or privileged any documents, materials or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

(d) The sharing of information and documents by the Commissioner pursuant to this Act shall not constitute a delegation of regulatory authority or rulemaking, and the Commissioner is solely responsible for the administration, execution and enforcement of the provisions of this Act.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials or other CGAD-related information shall occur as a result of

disclosure of such CGAD-related information or documents to the Commissioner under this section or as a result of sharing as authorized in this Act.

Sec. 5 (NEW) *(Effective January 1, 2017)* (a) The Commissioner may retain, at the insurer's expense, third-party consultants, including attorneys, actuaries, accountants and other experts not otherwise a part of the Commissioner's staff as may be reasonably necessary to assist the Commissioner in reviewing the CGAD and related information or the insurer's compliance with this Act.

(b). Any persons retained under subsection (a) of this section shall be under the direction and control of the Commissioner and shall act in a purely advisory capacity.

(c) The NAIC and third-party consultants shall be subject to the same confidentiality standards and requirements as the Commissioner.

(d) As part of the retention process, a third-party consultant shall verify to the Commissioner, with notice to the insurer, that it is free of a conflict of interest and that it has internal procedures in place to monitor compliance with a conflict and to comply with the confidentiality standards and requirements of this Act.

(e) A written agreement with the NAIC or a third-party consultant governing sharing and use of information provided pursuant to this Act shall contain the following provisions and expressly require the written consent of the insurer prior to making public information provided under this Act:

1. Specific procedures and protocols for maintaining the confidentiality and security of CGAD-related information shared with the NAIC or a third-party consultant pursuant to this Act;

2. Procedures and protocols for sharing by the NAIC only with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

3. A provision specifying that ownership of the CGAD-related information shared with the NAIC or a third-party consultant remains with the Department of Insurance and the NAIC's or third-party consultant's use of the information is subject to the direction of the Commissioner;

4. A provision that prohibits the NAIC or a third-party consultant from storing the information shared pursuant to this Act in a permanent database after the underlying analysis is completed;

5. A provision requiring the NAIC or third-party consultant to provide prompt notice to the Commissioner and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's CGAD-related information; and

6. A requirement that the NAIC or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this Act.

Sec. 6 (NEW) *(Effective January 1, 2017)* Any insurer failing, without just cause, to timely file the CGAD as required in this Act shall be required, after notice and hearing, to pay a penalty of $175.00 for each day the failure to file the report continues. The Commissioner may reduce the penalty if the insurer demonstrates to the Commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

Sec. 7. (NEW) *(Effective January 1, 2017)* If any provision of this Act other than section 4, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this Act which can be given effect without the invalid provision or application, and to that end the provisions of this Act, with the exception of section 4, are severable.

Sec. 8. Subdivision (8) of section 38a-250 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(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) <u>for each state in which it intends to operate,</u> 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. 9. Section 38a-250 of the general statutes is amended by adding subdivision (13) as follows:

(NEW) (*Effective October 1, 2016*) (13) "NAIC" means the National Association of Insurance Commissioners.

Sec. 10. Section 38a-251 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(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. 11. Section 38a-252 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(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. 12. Section 38a-253 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(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. 13. Section 38a-255 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

[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.

Sec. 14. Subdivision (a) of section 38a-91oo of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Unless otherwise provided in sections 38a-91aa to 83a-91tt, inclusive, no provision of this title shall apply to captive insurance companies, unless expressly included therein, except for the following: (1)Sections 38a-8, 38a-16, 38a-17, [38a-54 to38a-59] 38a-54, 38a-56 to 38a-59, inclusive, 38a-69a, 38a-102h and 38a-250 to 38a-266, inclusive, and chapter 704c; and subsection (d) of section 38a-72 and sections
38a-73 and 38a-129 to 38a-140, inclusive, which shall apply only to captive insurance companies formed as risk retention groups.

Agency Legislative Proposal - 2016 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: Commissioner Wade
Phone: 860-297-3801
E-mail: Katharine.Wade@ct.gov

Lead agency division requesting this proposal: Market Conduct Division (§ 1), Property & Casualty Division (§3)

Agency Analyst/Drafter of Proposal: Jon Arsenault / Tony Caporale

Title of Proposal
An Act Concerning Insurance Department Market Conduct Examination Authority and Data Call Confidentiality.

Statutory Reference: Conn. Gen. Stat. §§ 38a-15, 38a-16.

Proposal Summary

Section 1 amends Conn. Gen. Stat. § 38a-15 (market conduct statute) with respect to confidentiality of work papers and documents obtained by the Commissioner in the course of a market conduct examination, and immunity from suit in carrying out the provisions of this section.

Section 2 amends Conn. Gen. Stat. § 38a-16(a) to expressly reference the Commissioner's authority to issue data call and to provide for the confidentiality of company specific information (non-aggregated) provided to the Commissioner in response to the data call.

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

PROPOSAL BACKGROUND

Reason for Proposal: (1) Adoption of confidentiality and immunity provisions of market conduct examination workpapers (currently existing for financial examinations under Conn. Gen. Stat. § 38a-14) will facilitate the ability of the CID to lead NAIC multi-state market conduct examinations involving Connecticut domestic insurers.

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 concerning market conduct examinations; data call confidentiality is the norm among the states.

(3) *Have certain constituencies called for this action?*
The industry is believed to be supportive of the confidentiality provisions.

(4) *What would happen if this was not enacted in law this session?*
The lack of workpaper confidentiality will impair CID's ability to lead multi-state market conduct exams. The lack of confidentiality for information submitted in response to a data call will impair CID's ability to timely access and analyze information obtained from the industry with respect to a studies of market conditions and practices.

- **Origin of Proposal** **_X_ New Proposal - § 2** **_X_ Resubmission - § 1 has similar language to SB 871 (2015)**

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? **SB 871 (2015) passed the Senate, was amended in House and died in the Senate.**

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal? **The 2016 proposal omits language from last year's bill concerning retention of consultants at the expense of the insurer.**

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation? **CID/Sen. Crisco, Rep. Megna.**

(4) *What was the last action taken during the past legislative session?* **SB 871 failed to pass in the Senate on last day of the legislative session.**

PROPOSAL IMPACT

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

Agency Name: **No other agencies affected.**
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
N/A

Federal
N/A

Additional notes on fiscal impact

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

This legislation will protect the confidentiality of market conduct examination and data call information and thereby facilitate the CID's ability to act as lead state in multi-state market conduct examinations (§1) and in facilitate the CID in conducting data calls (§2).

AN ACT CONCERNING INSURANCE DEPARTMENT MARKET CONDUCT EXAMINATION AUTHORITY AND DATA CALL CONFIDENTIALITY.

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, 2016*):

(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) (1) All the expense of any examination made under the authority of this section, other than examinations of domestic insurance companies and domestic health care centers, shall be paid by the company, center, administrator or society examined. **[**, and domestic**]**

(2) No domestic insurance company or domestic health care center liable for an assessment levied under section 38a-47 shall pay, as costs associated with an examination made under the authority of this section, the salaries, fringe benefits and travel and maintenance expenses of examining personnel of the Insurance Department engaged in such examination, except that 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 given confidential treatment, shall not be subject to subpoena and shall not be made public by the commissioner or any other person except to the

extent provided in subsection (f) of this section. The commissioner may grant access to such workpapers, recorded information, documents and copies to the National Association of Insurance Commissioners provided said association agrees, in writing, to hold such workpapers, recorded information, documents and copies thereof confidential.

Sec. 2. Subsection (a) of section 38a-16 of the general statutes is repealed and the following is substituted in lieu thereof: (*Effective October 1, 2016*):

(a) The Insurance Commissioner or the commissioner's authorized representative may, as often as the commissioner deems necessary, conduct investigations and hearings in aid of any investigation on any matter under the provisions of this title. Pursuant to any such investigation or hearing, the commissioner or the commissioner's authorized representative may issue data calls, subpoenas, administer oaths, compel testimony, order the production of books, records, papers and documents, and examine books and records. If any person refuses to allow the examination of books and records, to appear, to testify or to produce any book, record, paper or document when so ordered, a judge of the Superior Court, upon application of the commissioner or the commissioner's authorized representative, may make such order as may be appropriate to aid in the enforcement of this section. Information provided in response to a data call under this section shall be confidential, shall not be subject to subpoena and shall not be made public by the commissioner or any other person, except nothing shall prevent or be construed as prohibiting the commissioner from disclosing data aggregated with data from other participants in the data call without identifying any individual participant.

Agency Legislative Proposal - 2016 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. The administrative judge for the Judicial District of Hartford shall appoint a single judge to handle the petition and order 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 at the expiration of such 24 hour period. Section 1 also sets 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** **__ New Proposal** **_X_ Resubmission**

If this is a resubmission, please share:

(1) *What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?* **In 2015, HB 6951 passed the House of Representatives as amended by House Amendment Schedule A, but dies on the Senate Calendar.**

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal? **Yes. The Insurance Department and the Judicial Department worked-out acceptable language which was reflected in House Amendment Schedule A (LCO 6833).**

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation? **The Insurance Commissioner, who serves as receiver of insurers when appointed by the Superior Court, and the State Judicial Department.**

(4) What was the last action taken during the past legislative session? **On May 30, 2015 HB 6951 passed the House; on May 31, 2015 it was tabled for the Senate Calendar (No. 640).**

PROPOSAL IMPACT

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

Agency Name: State of Connecticut Judicial Department
Agency Contact (name, title, phone): **Melissa A. Farley, Esq., Executive Director, State of Connecticut Judicial Branch, Division of External Affairs (860) 757-2270.**
Date Contacted: _____

Approve of Proposal _**X**__ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

The Judicial Branch representatives "are fine with the change" [in HB 6951 – proposed House Amendment]. May 6, 2015.

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, 2016*) (a) The provisions of this section shall apply in accordance with Title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act, P. L. 111-203, as amended from time to time, with respect to an insurer that is a covered financial company, as defined in 12 USC 5381, as amended from time to time.

(b) The Insurance Commissioner may file a petition with the clerk of the superior court for the judicial district of Hartford for an order authorizing the commissioner to rehabilitate or liquidate a domestic insurer on any one or more of the following grounds:

(1) (A) The Secretary of the Treasury of the United States, in consultation with the President of the United States, has determined that the insurer is a financial company that satisfies the requirements of 12 USC 5383(b), as amended from time to time, (B) such insurer has been notified by said Secretary of such determination, and (C) the board of directors or similar governing body of such insurer acquiesces or consents to the appointment of a receiver pursuant to 12 USC 5382(a)(1)(A)(i), as amended from time to time. Such acquiescence or consent shall be deemed to be consent to an order of rehabilitation or liquidation;

(2) The United States District Court for the District of Columbia has issued an order pursuant to 12 USC 5382(a)(1)(A)(iv)(I), as amended from time to time, granting the petition of said Secretary to appoint a receiver of such insurer under 12 USC 5382(a)(1)(A)(i), as amended from time to time; or

(3) A petition by said Secretary concerning such insurer has been granted by operation of law pursuant to 12 USC 5382(a)(1)(A)(v), as amended from time to time.

(c) Notwithstanding any other provision of chapter 704 of the general statutes, the superior court for the judicial district of Hartford may grant an order of rehabilitation or liquidation under subsection (b) of this section, after notifying such insurer, within twenty-four hours after the commissioner has filed the petition for such order. The filing of the petition shall satisfy the notice requirement to the insurer. The administrative judge of said district shall appoint a single judge to handle the petition and order.

(d) (1) If said court does not make a determination on such petition filed by the commissioner within twenty-four hours after such filing, the order of rehabilitation or liquidation shall be deemed granted at the expiration of such twenty-four-hour period. At the time such order is deemed granted under this subdivision, the provisions of chapter 704c of the general statutes shall be deemed to be in effect and the commissioner shall be deemed to be appointed as the receiver and have all applicable powers under chapter 704c of the general statutes, regardless of whether said court has entered an order of rehabilitation or liquidation.

(2) The said court shall expeditiously enter, if an order for rehabilitation or liquidation is deemed granted pursuant to subdivision (1) of this subsection, an order for rehabilitation or liquidation that (A) is effective as of the date such order is deemed granted pursuant to subdivision (1) of this subsection, and (B) conforms to the provisions for rehabilitation or liquidation, as applicable, under chapter 704c of the general statutes.

(e) No order of rehabilitation or liquidation under this section shall 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 sections 38a-903 to 38a-961 inclusive, of the general statutes.

Sec. 2. Subsection (a) of section 38a-930 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) (1) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one year before the filing of a successful petition for liquidation under sections 38a-903 to 38a-961, inclusive, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then such transfers shall be deemed preferences if made or suffered within one year before the filing of the successful petition for rehabilitation, or within two years before the filing of the successful petition for liquidation, whichever time is shorter.

(2) Any preference may be avoided by the liquidator if: (A) The insurer was insolvent at the time of the transfer; (B) the transfer was made within four months before the filing of the petition; (C) the creditor receiving it or to be benefited thereby or **[**his**]** <u>such creditor's</u> agent acting with reference thereto had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or (D) the creditor receiving it was an officer, or any employee or attorney or other person who was in fact in a position of comparable influence in the insurer to an officer whether or not **[**he**]** <u>such employee, attorney or other person</u> held such position, or any shareholder holding directly or indirectly more than five per **[**centum**]** <u>cent</u> of any class of any equity security issued by the insurer, or any other person, firm, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length.

(3) Where the preference is voidable, the liquidator may recover the property, or if it has been converted, its value from any person who has received or converted the property,

except where a bona fide purchaser or lienor has given less than fair equivalent value, **[**he**]** such purchaser or lienor shall have a lien upon the property to the extent of the consideration actually given by **[**him**]** such purchaser or lienor. Where a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate, in which event the lien or title shall pass to the liquidator.

(4) Notwithstanding subdivisions (1) to (3), inclusive, of this subsection, a transfer pursuant to a commutation of a reinsurance agreement that is approved by the commissioner or the commissioner's designated appointee under section 38a-962d shall not be voidable as a preference. For the purposes of this subdivision, 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, 2016*):

(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, accelerate 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) Any**]** (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) Subject**]** (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) No person who is a party to a netting agreement or qualified financial contract with an insurer that is the subject of an insolvency proceeding may exercise any contractual right to terminate, liquidate, accelerate or close out the obligations with respect to such agreement or contract because of the insolvency, financial condition or default of the insurer, or by the commencement of a formal delinquency proceeding under sections 38a-903 to 38a-961, inclusive, (A) until five o'clock p.m., eastern standard time, on the business day following the

date of appointment of a receiver, or (B) after such person has received notice that such agreement or 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, 2016*):

(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, 2016*)

JEA August 7, 2015

Agency Legislative Proposal - 2016 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:
Lead agency division requesting this proposal: CID
Agency Analyst/Drafter of Proposal: Mary Ellen Breault

Title of Proposal Licensure of Single Purpose Dental Health Care Center
Statutory Reference§38a-591b
Proposal Summary Allows a dental only health care center to be licensed in the state.
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?

This would potentially expand the number of entities licensed to offer dental insurance in the state.

- **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) None
State none
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

Sec. 38a-175. (Formerly Sec. 33-179a). Definitions. As used in sections 38a-175 to 38a-194:

(1) "Healing arts" means the professions and occupations licensed under the provisions of chapters 370, 372, 373, 375, 378, 379, 380, 381 and 383.

(2) "Carrier" means a health care center, insurer, hospital service corporation, medical service corporation or other entity responsible for the payment of benefits or provision of services under a group contract.

(3) "Commissioner" means the Insurance Commissioner, except when explicitly stated otherwise.

(4) "Evidence of coverage" means a statement of essential features and services of the health care center coverage which is given to the subscriber by the health care center or by the group contract holder.

(5) "Federal Health Maintenance Organization Act" means Title XIII of the Public Health Service Act, 42 USC Subchapter XI, as from time to time amended, or any successor thereto relating to qualified health maintenance organizations.

(6) "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

(7) "Group contract holder" means the person to which a group contract has been issued.

(8) "Health care" includes, but shall not be limited to, the following: (A) Except as provided in (B), Medical, surgical and dental care provided through licensed practitioners, including any supporting and ancillary personnel, services and supplies; physical therapy service provided through licensed physical therapists upon the prescription of a physician; psychological examinations provided by registered psychologists; optometric service provided by licensed optometrists; hospital service, both inpatient and outpatient; convalescent institution care and nursing home care; nursing service provided by a registered nurse or by a licensed practical nurse; home care service of all types required for the health of a person; rehabilitation service

required or desirable for the health of a person; preventive medical services of all and any types; furnishing necessary appliances, drugs, medicines and supplies; educational services for the health and well-being of a person; ambulance service; and any other care, service or treatment related to the prevention or treatment of disease, the correction of defects and the maintenance of the physical and mental well-being of human beings. Any diagnosis and treatment of diseases of human beings required for health care as defined in this section, if rendered, shall be under the supervision and control of the providers; (B) For health care centers that provide only dental services, dental care provided through licensed practitioners, including any supporting and ancillary personnel, services and supplies.

(9) "Health care center" means either: (A) A person, including a profit or a nonprofit corporation organized under the laws of this state for the purpose of carrying out the activities and purposes set forth in subsection (b) of section 38a-176, at the expense of the health care center, including the providing of health care, as herein defined, to members of the community, including subscribers to one or more plans under an agreement entitling such subscribers to health care in consideration of a basic advance or periodic charge and shall include a health maintenance organization, or (B) a line of business conducted by an organization that is formed, pursuant to the laws of this state for the purposes of, but not limited to, carrying out the activities and purposes set forth in subsection (b) of section 38a-176.

(10) "Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the subscriber.

(11) "Individual practice association" means a partnership, corporation, association, or other legal entity which has entered into a services arrangement with health care professionals licensed in this state to provide services to enrollees of a health care center.

(12) "Insolvent" or "insolvency" means that the organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction.

(13) “Net worth” means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt as defined in section 38a-193.

(14) “Member” or “enrollee” means an individual who is enrolled in a health care center.

(15) “Person” means an individual, corporation, limited liability company, partnership, association, trust or any other legal entity.

(16) “Uncovered expenditures” means the cost of health care services that are covered by a health care center, for which an enrollee would also be liable in the event of the center’s insolvency, and for which no alternative arrangements have been made that are acceptable to the commissioner. Uncovered expenditures shall not include expenditures for services when a provider has agreed not to bill the enrollee even though the provider is not paid by the health care center or for services that are guaranteed, insured or assumed by a person other than the health care center.

(17) “Enrolled population” means a group of persons, defined as to probable age, sex and family composition, which receives health care from a health care center in consideration of a basic advance or periodic charge.

(18) “Participating provider” means a provider who, under an express or implied contract with the health care center or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health care center.

(19) “Provider” means any licensed health care professional or facility, including individual practice associations.

(20) “Subscriber” means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health care center, or in the case of an individual contract, the person in whose name the contract is issued.

Sec. 38a-176. (Formerly Sec. 33-179b). Applicable statutes. Activities and purposes of health care center. (a) Each such health care center shall be governed

by sections 38a-175 to 38a-192, inclusive, and by the other applicable laws of the state to the extent not inconsistent with the provisions of said sections.

(b) The nature of the activities to be conducted and the purposes to be carried out by a health care center include, but are not limited to: (1) Establishing, maintaining and operating facilities whereby health care, as hereinbefore defined, may be provided at the expense of the health care center; and (2) providing health care directly by its health care center employees who, when required by law, shall be duly licensed to render such service or by agreement or by indemnity arrangement with any hospital, hospital service corporation, medical service corporation, medical group clinic or person qualified and licensed to render any health care service or by both methods. [; (3) entering into agreements with any governmental agency, or any provider for the training of personnel under the direction of persons licensed to practice any healing art; (4) establishing, operating and maintaining a medical service center, clinic or any such other facility as shall be necessary for the prevention, study, diagnosis and treatment of human ailments and injuries and to promote medical, surgical, dental and general health education, scientific education, research and learning; (5) marketing, enrolling and administering a health care plan; (6) contracting with insurers licensed in this state, including hospital and medical service corporations; (7) offering, in addition to health services, benefits covering out-of-area or emergency services; (8) providing health services not included in the health care plan on a fee-for-service basis; and (9) entering into contracts in furtherance of the purposes of sections 38a-175 to 38a-192.]

(c) Activities to be conducted and the purposes to be carried out by a health care center that provides medical and surgical services include (1) entering into agreements with any governmental agency, or any provider for the training of personnel under the direction of persons licensed to practice any healing art; (2) establishing, operating and maintaining a medical service center, clinic or any such other facility as shall be necessary for the prevention, study, diagnosis and treatment of human ailments and injuries and to promote medical, surgical, dental and general health education, scientific education, research and learning; (3) marketing, enrolling and administering a health care plan; (4) contracting with insurers licensed in this state, including hospital and medical service corporations; (5) offering, in addition to health services, benefits covering out-of-area or emergency services; (6) providing health services not included in the health care plan on a fee-for-service basis; and (7)

entering into contracts in furtherance of the purposes of sections 38a-175 to 38a-192.

(d) Health care centers that offer only dental services shall not be required to conduct activities in subsection (c).

Sec. 38a-177. (Formerly Sec. 33-179c). Manner of providing health care. Health care may be provided (a) directly by a health care center or by its employees or contractors licensed by this state to render such services, or by contract or by indemnity arrangement with any hospital, hospital service corporation, medical service corporation or person qualified and licensed to render any health care service or by both methods; and (b) by other methods to the extent permitted under the Federal Health Maintenance Organization Act and the regulations adopted thereunder from time to time unless otherwise determined by the commissioner by regulation. A health care center may also enter into agreements with hospitals or individuals approved by their respective state regulating board, licensed to practice any of the healing arts, for the training of personnel under the direction of persons licensed to practice the profession or healing art. A health care center may also maintain a clinic or clinics for the prevention, study, diagnosis and treatment of human ailments and injuries by licensed persons and to promote medical, surgical, dental [and] or scientific research and learning.

Sec. 38a-179. (Formerly Sec. 33-179g). Management of health care center. Directors. (a) If the health care center is organized as a nonprofit, nonstock corporation, the care, control and disposition of the property and funds of each such corporation and the general management of its affairs shall be vested in a board of directors. Each such corporation shall have the power to adopt bylaws for the governing of its affairs, which bylaws shall prescribe the number of directors, their term of office and the manner of their election, subject to the provisions of sections 38a-175 to 38a-192, inclusive. The bylaws may be adopted and repealed or amended by the affirmative vote of two-thirds of all the directors at any meeting of the board of directors duly held upon at least ten days' notice, provided notice of such meeting shall specify the proposed action concerning the bylaws to be taken at such meeting. The bylaws of the corporation shall provide that the board of directors shall include representation from persons engaged in the healing arts and from persons who are eligible to receive health care from the corporation, subject to the following provisions: (1) One-quarter of the board of directors shall be persons engaged in the

different fields in the healing arts at least two of whom shall be a physician and a dentist; (2) one-quarter of the board of directors shall be subscribers who are eligible to receive health care from the health care center, but no such representative need be seated until the first annual meeting following the approval by the commissioner of the initial agreement or agreements to be offered by the corporation, and there shall be only one representative from any group covered by a group service agreement.

(b) If the health care center is not organized as a nonprofit, nonstock corporation, management of its affairs shall be in accordance with other applicable laws of the state, provided that the health care center shall establish and maintain a mechanism to afford its members an opportunity to participate in matters of policy and operation such as an advisory panel, advisory referenda on major policy decisions or other similar mechanisms.

(c) Health care centers that offer only dental services may substitute persons who are engaged in dental or related fields for persons in different fields in the healing arts in subdivision (1) of subsection (a),

Sec. 38a-180. (Formerly Sec. 33-179h). Clinics. Liability of practitioners to reprimand or discipline. Choice in selection of practitioner. (a) Any clinic established hereunder, including a clinic which is a part of a medical service center or other facility, shall be subject to approval as a clinic by the Commissioner of Public Health pursuant to the standards established by him for approved clinics.

(b) Any person licensed to practice any of the healing arts or occupations employed by a health care center governed by sections 38a-175 to 38a-192, inclusive, shall not be subject to reprimand or discipline because he is an employee of the health care center or because such center may be engaged in rendering health care or related care through its own employees, provided such person shall otherwise remain subject to reprimand or discipline for his act or acts for unlawful, unprofessional or immoral conduct by the state regulating board governing such profession or occupation as provided by law.

(c) No health care center offering medical services that [which] contracts with an individual practice association may prohibit any practitioner of the healing arts from

participating in such center solely on the basis of his profession. No person may interfere with the exercise by any other person of his free choice in the selection of a practitioner in the healing arts in the health care center.

(d) No health care center that offers only dental services may prohibit any practitioner of the healing arts from participating solely on the basis of his profession if such practitioner is licensed to perform services offered by the health care center. No person may interfere with the exercise by any other person of his free choice in the selection of a practitioner in the healing arts in the health care center.