House of Representatives

General Assembly

File No. 644

February Session, 2024

Substitute House Bill No. 5503

House of Representatives, May 1, 2024

The Committee on Insurance and Real Estate reported through REP. WOOD of the 29th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING INSURANCE MARKET CONDUCT AND INSURANCE LICENSING, THE INSURANCE DEPARTMENT'S TECHNICAL CORRECTIONS AND OTHER REVISIONS TO THE INSURANCE STATUTES AND CAPTIVE INSURANCE.

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

Section 1. Section 38a-8 of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) The commissioner shall see that all laws respecting insurance companies and health care centers are faithfully executed and shall administer and enforce the provisions of this title. The commissioner shall have all powers specifically granted, and all further powers that are reasonable and necessary to enable the commissioner to protect the public interest in accordance with the duties imposed by this title, including, but not limited to, the power to order restitution of any sums obtained in violation of any provision of this title, or any regulation or order adopted or issued pursuant to this title by the commissioner, plus

interest at the rate set forth in section 37-3a. The commissioner shall pay to the Treasurer all the fees that the commissioner receives. The commissioner may administer oaths in the discharge of the commissioner's duties.

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

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

(d) The commissioner shall develop a program of periodic review to ensure compliance by the Insurance Department with the minimum standards established by the National Association of Insurance Commissioners for effective financial surveillance and regulation of insurance companies operating in this state. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, pertaining to the financial surveillance and solvency regulation of insurance companies and health care centers as are reasonable and necessary to obtain or maintain the accreditation of the Insurance Department by the National Association of Insurance Commissioners. The commissioner shall maintain as confidential any confidential documents or information received from the National Association of Insurance Commissioners, or the International Association of Insurance Supervisors, or any documents or information received from state or federal insurance, banking or securities regulators or similar regulators in a foreign country that are confidential in such jurisdictions. The commissioner may share any information, including confidential information, with the National Association of Insurance Commissioners, the International Association of Insurance Supervisors, or state or federal insurance, banking or securities regulators or similar regulators in a foreign country, provided the commissioner determines that such entities agree to maintain the same level of confidentiality in

their jurisdictions as is available in this state. At the expense of a domestic, alien or foreign insurer, the commissioner may engage the services of attorneys, actuaries, accountants and other experts not otherwise part of the commissioner's staff as may be necessary to assist the commissioner in the financial analysis of the insurer, the review of the insurer's license applications, and the review of transactions within a holding company system involving an insurer domiciled in this state. No duties of a person employed by the Insurance Department on November 1, 2002, shall be performed by such attorney, actuary, accountant or expert.

(e) The commissioner shall establish a program to reduce costs and increase efficiency through the use of electronic methods to transmit documents, including policy form and rate filings, to and from insurers and the Insurance Department. The commissioner may sit as a member of the board of a consortium organized by or in association with the National Association of Insurance Commissioners for the purpose of coordinating a system for electronic rate and form filing among state insurance departments and insurers.

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

(g) The commissioner may, in the commissioner's discretion, engage the services of such third-party actuaries, professionals and specialists that the commissioner deems necessary to assist the commissioner in

reviewing any rate, form or similar filing submitted to the commissioner pursuant to this title. The cost of such services shall be borne by the person who submitted such rate, form or similar filing to the commissioner.

(h) The commissioner shall promote the development and growth of, and employment opportunities within, the insurance industry in the state.

(i) (1) Whenever the commissioner finds that any person has engaged in or is about to engage in any act, practice or omission that constitutes, or will constitute, a violation of any section of this title, or any regulation or order adopted or issued by the commissioner implementing the provisions of this title, the Attorney General may, at the request of the commissioner, bring an action in the superior court for the judicial district of Hartford for an order: (A) Enjoining such act, practice or omission. Upon a showing by the commissioner that such person has engaged in or is about to engage in any such act, practice or omission, the court may issue a permanent or temporary injunction, restraining order or other order, as appropriate. The commissioner shall not be required to post a bond in such action; (B) imposing a penalty not to exceed one hundred thousand dollars per violation against any such person found by the commissioner to have violated any such section, regulation or order; or (C) providing restitution against such person for any sums shown by the commissioner to have been obtained by such person in violation of any such section, regulation or order, plus interest at the rate set forth in section 37-3a.

(2) Whenever the commissioner prevails in any action brought under this subsection, the court may allow to the state any costs of such action.

Sec. 2. Section 38a-16 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) (1) The Insurance Commissioner or the commissioner's authorized representative may, as often as the commissioner deems necessary, conduct investigations and hearings in aid of any investigation on any

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

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

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

Sec. 3. Subsection (a) of section 38a-790 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

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

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

Sec. 4. Subsection (a) of section 38a-792 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) (1) No person may act as an adjuster of casualty claims for any insurance company or firm or corporation engaged in the adjustment of casualty claims unless such person has first secured a license from the commissioner, and has paid the license fee specified in section 38a-11, for each two-year period or fraction thereof. Application for such license shall be made as provided in section 38a-769. Any [such license issued by the commissioner shall be in force until June thirtieth in each odd-numbered year] initial license issued to an adjuster of casualty claims shall expire two years after the date of the licensee's birthday that preceded the date the license was issued unless sooner revoked or suspended. The [person] licensee may, at the discretion of the commissioner, renew the license biennially thereafter upon payment of the fee specified in section 38a-11.

(2) The commissioner may waive the examination required under section 38a-769, in the case of any applicant for a casualty claims adjuster's license that (A) is a nonresident of this state or has its principal place of business in another state, and holds an equivalent license from any other state, or (B) at any time within two years next preceding the date of application has been licensed in this state under a license of the same type as the license applied for.

Sec. 5. Section 38a-48 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

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

(b) On or before July thirty-first, annually, the Insurance Commissioner **[**and the Office of the Healthcare Advocate**]** shall render to each domestic insurance company or other domestic entity liable for payment under section 38a-47: (1) A statement that includes (A) the amount appropriated to the Insurance Department, the Office of the Healthcare Advocate and the Office of Health Strategy from the Insurance Fund established under section 38a-52a for the fiscal year beginning July first of the same year, (B) the cost of fringe benefits for department and office personnel for such year, as estimated by the Comptroller, (C) the estimated expenditures on behalf of the department and the offices from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year, not including such estimated expenditures made on behalf of the Health Systems Planning Unit of the Office of Health Strategy, and (D) the amount appropriated to the Department of Aging and Disability Services for the fall prevention program established in section 17a-859 from the Insurance Fund for the fiscal year; (2) a statement of the total taxes imposed on all domestic insurance companies and domestic insurance entities under chapter 207 on business done in this state during the preceding calendar year; and (3) the proposed assessment against that company or entity, calculated in accordance with the provisions of subsection (c) of this section, provided for the purposes of this calculation the amount appropriated to the Insurance Department, the Office of the Healthcare Advocate and the Office of Health Strategy from the Insurance Fund plus the cost of

fringe benefits for department and office personnel and the estimated expenditures on behalf of the department and **[**the office**]** such offices from the Capital Equipment Purchase Fund pursuant to section 4a-9, not including such expenditures made on behalf of the Health Systems Planning Unit of the Office of Health Strategy shall be deemed to be the actual expenditures of the department and **[**the office**]** such offices, and the amount appropriated to the Department of Aging and Disability Services from the Insurance Fund for the fiscal year for the fall prevention program established in section 17a-859 shall be deemed to be the actual expenditures for the program.

(c) (1) The proposed assessments for each domestic insurance company or other domestic entity shall be calculated by (A) allocating twenty per cent of the amount to be paid under section 38a-47 among the domestic entities organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, in proportion to their respective shares of the total taxes and charges imposed under chapter 207 on such entities on business done in this state during the preceding calendar year, and (B) allocating eighty per cent of the amount to be paid under section 38a-47 among all domestic insurance companies and domestic entities other than those organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, in proportion to their respective shares of the total taxes and charges imposed under chapter 207 on such domestic insurance companies and domestic entities on business done in this state during the preceding calendar year, provided if there are no domestic entities organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, at the time of assessment, one hundred per cent of the amount to be paid under section 38a-47 shall be allocated among such domestic insurance companies and domestic entities.

(2) When the amount any such company or entity is assessed pursuant to this section exceeds twenty-five per cent of the actual expenditures of the Insurance Department, the Office of the Healthcare Advocate and the Office of Health Strategy from the Insurance Fund, such excess amount shall not be paid by such company or entity but

rather shall be assessed against and paid by all other such companies and entities in proportion to their respective shares of the total taxes and charges imposed under chapter 207 on business done in this state during the preceding calendar year, except that for purposes of any assessment made to fund payments to the Department of Public Health to purchase vaccines, such company or entity shall be responsible for its share of the costs, notwithstanding whether its assessment exceeds twenty-five per cent of the actual expenditures of the Insurance Department, the Office of the Healthcare Advocate and the Office of Health Strategy from the Insurance Fund. The provisions of this subdivision shall not be applicable to any corporation **[**which**]** that has converted to a domestic mutual insurance company pursuant to section 38a-155 upon the effective date of any public act **[**which**]** that amends said section to modify or remove any restriction on the business such a company may engage in, for purposes of any assessment due from such company on and after such effective date.

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

[(e) On or before September thirtieth, annually, for each fiscal year ending prior to July 1, 1990, the Insurance Commissioner and the Healthcare Advocate, after receiving any objections to the proposed assessments and making such adjustments as in their opinion may be indicated, shall assess each such domestic insurance company or other domestic entity an amount equal to its proposed assessment as so adjusted. Each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner on or before October thirty-

first an amount equal to fifty per cent of its assessment adjusted to reflect any credit or amount due from the preceding fiscal year as determined by the commissioner under subsection (g) of this section. Each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner on or before the following April thirtieth, the remaining fifty per cent of its assessment.**]**

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

[(g)**]** (f) If the actual expenditures for the fall prevention program established in section 17a-859 are less than the amount allocated, the Commissioner of Aging and Disability Services shall notify the Insurance Commissioner. **[**and the Healthcare Advocate.**]** Immediately following the close of the fiscal year, the Insurance Commissioner **[**and the Healthcare Advocate**]** shall recalculate the proposed assessment for each domestic insurance company or other domestic entity in accordance with subsection (c) of this section using the actual

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

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

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

Sec. 6. Subsection (a) of section 38a-53 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) (1) Each domestic insurance company or domestic health care center shall, annually, on or before the first day of March, submit to the

commissioner, [and] by electronically [to] filing with the National Association of Insurance Commissioners, a true and complete report, signed and sworn to by its president or a vice president, and secretary or an assistant secretary, of its financial condition on the thirty-first day of December next preceding, prepared in accordance with the National Association of Insurance Commissioners annual statement instructions handbook and following those accounting procedures and practices prescribed by the National Association of Insurance Commissioners accounting practices and procedures manual, subject to any deviations in form and detail as may be prescribed by the commissioner. An electronically filed report in accordance with section 38a-53a that is timely submitted to the National Association of Insurance Commissioners shall [not exempt a domestic insurance company or domestic health care center from timely filing a true and complete paper copy with the commissioner] be deemed to have been submitted to the commissioner in accordance with the provisions of this section.

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

Sec. 7. Subsection (a) of section 38a-54 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

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

complete paper copy to the commissioner**]** shall be deemed to have been submitted to the commissioner in accordance with the provisions of this section.

Sec. 8. Section 38a-297 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

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

(b) The commissioner may authorize a lower score than the Flesch reading ease score required in subsection (a) whenever **[**he**]** the commissioner finds that a lower score (1) will provide a more accurate reflection of the readability of a policy form; (2) is warranted by the nature of a particular policy form or type or class of policy forms; or (3)

is the result of language which is used to conform to the requirements of any state or federal law, regulation or governmental agency.

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

(d) Filings subject to this section may be filed with the commissioner in any language. Any non-English-language policy shall be deemed to be in compliance with subsection (a) of this section if the insurer certifies that such policy **[**is translated from an English-language policy that**]** complies with **[**said**]** subsection (a) of this section or is translated from a policy that complies with subsection (a) of this section.

(e) The commissioner may engage the services of any translation service, as needed, to review any non-English-language policy filed with the commissioner pursuant to this section, the cost of which shall be borne by the insurer that submits such filing.

(f) (1) For any insurer that files a non-English-language policy with the commissioner, the commissioner may require that such insurer either (A) provide an English translated copy of such policy and a certification as to the accuracy of such translated copy of such policy, or (B) pay all costs associated with the translation of such policy in accordance with the provisions of subsection (e) of this section.

(2) Any insurer shall accept all risk associated with any translation of such insurer's non-English-language policy in accordance with subdivision (1) of this subsection and subsection (e) of this section.

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

Sec. 9. Section 38a-479ppp of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2025*):

(a) Not later than **[**March 1, 2021**]** February 1, 2025, and annually thereafter, each pharmacy benefits manager shall file a report with the commissioner for the immediately preceding calendar year. The report shall contain the following information for health carriers that delivered, issued for delivery, renewed, amended or continued health care plans that included a pharmacy benefit managed by the pharmacy benefits manager during such calendar year:

(1) The aggregate dollar amount of all rebates concerning drug formularies used by such health carriers that such manager collected from pharmaceutical manufacturers that manufactured outpatient prescription drugs that (A) were covered by such health carriers during such calendar year, and (B) are attributable to patient utilization of such drugs during such calendar year; and

(2) The aggregate dollar amount of all rebates, excluding any portion of the rebates received by such health carriers, concerning drug formularies that such manager collected from pharmaceutical manufacturers that manufactured outpatient prescription drugs that (A) were covered by such health carriers during such calendar year, and (B) are attributable to patient utilization of such drugs by covered persons under such health care plans during such calendar year.

(b) The commissioner shall establish a standardized form for reporting information pursuant to subsection (a) of this section after consultation with pharmacy benefits managers. The form shall be designed to minimize the administrative burden and cost of reporting on the department and pharmacy benefits managers.

(c) All information submitted to the commissioner pursuant to subsection (a) of this section shall be exempt from disclosure under the Freedom of Information Act, as defined in section 1-200, except to the extent such information is included on an aggregated basis in the report required by subsection (d) of this section. The commissioner shall not

disclose information submitted pursuant to subdivision (1) of subsection (a) of this section, or information submitted pursuant to subdivision (2) of said subsection in a manner that (1) is likely to compromise the financial, competitive or proprietary nature of such information, or (2) would enable a third party to identify a health care plan, health carrier, pharmacy benefits manager, pharmaceutical manufacturer, or the value of a rebate provided for a particular outpatient prescription drug or therapeutic class of outpatient prescription drugs.

(d) Not later than **[**March 1, 2022**]** March 1, 2025, and annually thereafter, the commissioner shall submit a report, in accordance with section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance. The report shall contain (1) an aggregation of the information submitted to the commissioner pursuant to subsection (a) of this section for the immediately preceding calendar year, and (2) such other information as the commissioner, in the commissioner's discretion, deems relevant for the purposes of this section. Not later than **[**February 1, 2022, and annually thereafter**]** ten days prior to the submission of the annual report pursuant to the provisions of this subsection, the commissioner shall provide each pharmacy benefits manager and any third party affected by submission of **[**a**]** such report required by this subsection with a written notice describing the content of the report.

(e) The commissioner may impose a penalty of not more than seven thousand five hundred dollars on a pharmacy benefits manager for each violation of this section.

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

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

(a) There is hereby created a nonprofit legal entity to be known as the Health Reinsurance Association. All insurers, health care centers and

self-insurers doing business in the state, as a condition to their authority to transact the applicable kinds of health insurance defined in section 38a-551, shall be members of the association. The association shall perform its functions under a plan of operation established and approved under subsection (b) of this section, and shall exercise its powers through a board of directors established under this section.

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

(2) The board shall submit to the commissioner a plan of operation for the association necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation shall become effective upon approval in writing by the commissioner. Such plan shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner. The plan of operation shall: (A) Establish procedures for the handling and accounting of assets and moneys of the association; (B) establish regular times and places for meetings of the board of directors; (C) establish procedures for records to be kept of all financial

transactions, and for the annual fiscal reporting to the commissioner; (D) establish procedures whereby selections for the board of directors shall be made and submitted to the commissioner; (E) establish procedures to amend, subject to the approval of the commissioner, the plan of operations; (F) establish procedures for the selection of an administrator and set forth the powers and duties of the administrator; (G) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and (H) contain additional provisions necessary for the association to establish health insurance plans that qualify as acceptable coverage in accordance with the Pension Benefit Guaranty Corporation and other state or federal programs that may be established.

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

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

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

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

of paid health losses for the applicable period by eighty-five per cent. Net gains, if any, shall be held at interest to offset future losses or allocated to reduce future premiums.

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

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

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

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

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

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

Sec. 11. Subdivision (4) of section 38a-564 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

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

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

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

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

Sec. 12. Subdivision (1) of section 38a-614 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(1) Each domestic society transacting business in this state shall, annually, on or before the first day of March, unless the commissioner has extended such time for cause shown, file with the commissioner, and electronically to the National Association of Insurance Commissioners, a true and complete statement of its financial condition, transactions and affairs for the preceding calendar year and pay the fee specified in section 38a-11 for filing such annual statement. The statement shall be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the commissioner. An electronically filed true and complete report filed in accordance with section 38a-53a that is timely submitted to the National Association of Insurance Commissioners shall [not exempt a

domestic society from timely filing a true and complete paper copy with the commissioner**]** be deemed to have been submitted to the commissioner in accordance with the provisions of this section.

Sec. 13. Subsection (b) of section 38a-591*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

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

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

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

Sec. 14. Section 38a-91aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

As used in this section, sections 38a-91bb to 38a-91uu, inclusive, **[**and**]** sections 38a-91ww, **[**and**]** 38a-91xx and section 15 of this act:

(1) "Affiliated company" means any company in the same corporate system as a parent, an industrial insured or a member organization by

virtue of common ownership, control, operation or management.

(2) "Agency captive insurance company" means a captive insurance company that:

(A) Is owned or directly or indirectly controlled by one or more insurance agents or insurance producers licensed in accordance with sections 38a-702a to 38a-702r, inclusive;

(B) Only insures against risks covered by insurance policies sold, solicited or negotiated through the insurance agents or insurance producers that own or control such captive insurance company; and

(C) Does not insure against risks covered by any health insurance policy or plan.

(3) "Alien captive insurance company" means any insurance company formed to write insurance business for its parent and affiliated companies and licensed pursuant to the laws of an alien jurisdiction that imposes statutory or regulatory standards on companies transacting the business of insurance in such jurisdiction that the commissioner deems to be acceptable.

(4) "Association" means any legal association of individuals, corporations, limited liability companies, partnerships, associations or other entities, where the association itself or some or all of the member organizations:

(A) Directly or indirectly own, control or hold with power to vote all of the outstanding voting securities or other voting interests of an association captive insurance company incorporated as a stock insurer;

(B) Have complete voting control over an association captive insurance company incorporated as a mutual corporation or formed as a limited liability company; or

(C) Constitute all of the subscribers of an association captive insurance company formed as a reciprocal insurer.

(5) "Association captive insurance company" means any company that insures risks of the member organizations of an association, and includes a company that also insures risks of such member organizations' affiliated companies or of the association.

(6) "Branch business" means any insurance business transacted in this state by a branch captive insurance company.

(7) "Branch captive insurance company" means any alien captive insurance company or foreign captive insurance company licensed by the commissioner to transact the business of insurance in this state through a business unit with a principal place of business in this state.

(8) "Branch operations" means any business operations in this state of a branch captive insurance company.

(9) "Captive insurance company" means any (A) pure captive insurance company, agency captive insurance company, association captive insurance company, industrial insured captive insurance company, risk retention group, sponsored captive insurance company or special purpose financial captive insurance company that is domiciled in this state and formed or licensed under the provisions of this section and sections 38a-91bb to 38a-91tt, inclusive, or (B) branch captive insurance company.

(10) "Ceding insurer" means an insurance company, approved by the commissioner and licensed or otherwise authorized to transact the business of insurance or reinsurance in its state or country of domicile, that cedes risk to a special purpose financial captive insurance company pursuant to a reinsurance contract.

(11) "Commissioner" means the Insurance Commissioner.

(12) "Controlled unaffiliated business" means any person:

(A) Who, (i) in the case of a pure captive insurance company, is not in the corporate system of a parent and the parent's affiliated companies, (ii) in the case of an industrial insured captive insurance company, is not

in the corporate system of an industrial insured and the industrial insured's affiliated companies, or (iii) in the case of a sponsored captive insurance company, is not in the corporate system of a participant and the participant's affiliated companies;

(B) Who, (i) in the case of a pure captive insurance company, has an existing contractual relationship with a parent or one of the parent's affiliated companies, (ii) in the case of an industrial insured captive insurance company, has an existing contractual relationship with an industrial insured or one of the industrial insured's affiliated companies, or (iii) in the case of a sponsored captive insurance company, has an existing contractual relationship with a participant or one of the participant's affiliated companies; and

(C) Whose risks are managed by a pure captive insurance company, an industrial insured captive insurance company or a sponsored captive insurance company, as applicable, in accordance with section 38a-91qq.

(13) "Excess workers' compensation insurance" means, in the case of an employer that has insured or self-insured its workers' compensation risks in accordance with applicable state or federal law, insurance in excess of a specified per-incident or aggregate limit established by the commissioner.

(14) "Foreign captive insurance company" means any insurance company formed to write insurance business for its parent and affiliated companies and licensed pursuant to the laws of a foreign jurisdiction that imposes statutory or regulatory standards on companies transacting the business of insurance in such jurisdiction that the commissioner deems to be acceptable.

(15) "Incorporated protected cell" means a protected cell that is established as a corporation or a limited liability company, separate from the sponsored captive insurance company with which it has entered into a participant contract.

(16) "Industrial insured" means an insured:

(A) Who procures the insurance of any risk or risks by use of the services of a full-time employee acting as an insurance manager or buyer;

(B) Whose aggregate annual premiums for insurance on all risks total at least twenty-five thousand dollars; and

(C) Who has at least twenty-five full-time employees.

(17) "Industrial insured captive insurance company" means any company that insures risks of the industrial insureds that comprise an industrial insured group, and includes a company that also insures risks of such industrial insureds' affiliated companies.

(18) "Industrial insured group" means any group of industrial insureds that collectively:

(A) Directly or indirectly own, control or hold with power to vote all of the outstanding voting securities or other voting interests of an industrial insured captive insurance company incorporated as a stock insurer;

(B) Have complete voting control over an industrial insured captive insurance company incorporated as a mutual corporation or formed as a limited liability company; or

(C) Constitute all of the subscribers of an industrial insured captive insurance company formed as a reciprocal insurer.

(19) "Insurance securitization" or "securitization" means a transaction or a group of related transactions, which may include capital market offerings, that are effected through related risk transfer instruments and facilitating administrative agreements, in which all or part of the result of such transaction is used to fund a special purpose financial captive insurance company's obligations under a reinsurance contract with a ceding insurer and by which:

(A) A special purpose financial captive insurance company directly

or indirectly obtains proceeds through the issuance of securities by such company or any other person; or

(B) A person provides, for the benefit of a special purpose financial captive insurance company, one or more letters of credit or other assets that the commissioner has authorized such company to treat as admitted assets for purposes of its annual report. "Insurance securitization" or "securitization" does not include the issuance of a letter of credit for the benefit of the commissioner to satisfy all or part of a special purpose financial captive insurance company's capital and surplus requirements under section 38a-91dd.

(20) "Member organization" means any individual, corporation, limited liability company, partnership, association or other entity that belongs to an association.

(21) "Mutual corporation" means a corporation organized without stockholders and includes a nonprofit corporation with members.

(22) "Parent" means any individual, corporation, limited liability company, partnership or other entity that directly or indirectly owns, controls or holds with power to vote more than fifty per cent of the outstanding voting:

(A) Securities of a pure captive insurance company organized as a stock insurer; or

(B) Membership interests of a pure captive insurance company organized as a nonprofit corporation or as a limited liability company.

(23) "Participant" means any association, corporation, limited liability company, partnership, trust or other entity, and any affiliated company or controlled unaffiliated business thereof, that is insured by a sponsored captive insurance company pursuant to a participant contract.

(24) "Participant contract" means a contract entered into by a sponsored captive insurance company and a participant by which the

sponsored captive insurance company insures the risks of the participant and limits the losses of each such participant to its pro rata share of the assets of one or more protected cells identified in such participant contract.

(25) "Protected cell" means a separate account established by a sponsored captive insurance company, in which assets are maintained for one or more participants in accordance with the terms of one or more participant contracts to fund the liability of the sponsored captive insurance company assumed on behalf of such participants as set forth in such participant contracts.

(26) "Pure captive insurance company" means any company that insures risks of its parent and affiliated companies or controlled unaffiliated business.

(27) "Reinsurance contract" means a contract entered into by a special purpose financial captive insurance company and a ceding insurer by which the special purpose financial captive insurance company agrees to provide reinsurance to the ceding insurer for risks associated with the ceding insurer's insurance or reinsurance business.

(28) "Risk retention group" means a captive insurance company organized under the laws of this state pursuant to the federal Liability Risk Retention Act of 1986, 15 USC 3901 et seq., as amended from time to time, as a stock insurer or mutual corporation, a reciprocal or other limited liability entity.

(29) "Security" has the same meaning as provided in section 36b-3 and includes any form of debt obligation, equity, surplus certificate, surplus note, funding agreement, derivative or other financial instrument that the commissioner designates as a security for purposes of this section and sections 38a-91bb to 38a-91tt, inclusive.

(30) "Special purpose financial captive insurance company" means a company that is licensed by the commissioner in accordance with section 38a-91bb.

(31) "Special purpose financial captive insurance company security" means a security issued by (A) a special purpose financial captive insurance company, or (B) a third party, the proceeds of which are obtained directly or indirectly by a special purpose financial captive insurance company.

(32) "Sponsor" means any association, corporation, limited liability company, partnership, trust or other entity that is approved by the commissioner to organize and operate a sponsored captive insurance company and to provide all or part of the required unimpaired paid-in capital and surplus.

(33) "Sponsored captive insurance company" means a captive insurance company:

(A) In which the minimum required unimpaired paid-in capital and surplus are provided by one or more sponsors;

(B) That insures risks of its participants only through separate participant contracts; and

(C) That funds its liability to each participant through one or more protected cells and segregates the assets of each protected cell from the assets of other protected cells and from the assets of the sponsored captive insurance company's general account.

(34) "Surplus note" means an unsecured subordinated debt obligation possessing characteristics consistent with the National Association of Insurance Commissioners Statement of Statutory Accounting Principles No. 41, as amended from time to time, and as modified or supplemented by the commissioner.

Sec. 15. (NEW) (*Effective October 1, 2024*) (a) (1) Any sponsored captive insurance company, including a sponsored captive insurance company licensed as a special purpose financial captive insurance company, may, upon application of such sponsored captive insurance company and with the commissioner's prior written approval, convert one or more protected cells or incorporated protected cells into a:

(A) Single protected cell or incorporated protected cell;

(B) New sponsored captive insurance company;

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

(D) New special purpose financial captive insurance company;

(E) New pure captive insurance company;

(F) New risk retention group;

(G) New agency captive insurance company;

(H) New industrial insured captive insurance company; or

(I) New association captive insurance company.

(2) Any such conversion of a protected cell or incorporated protected cell, in accordance with subdivision (1) of this subsection, shall be subject to the provisions of sections 38a-91aa to 38a-91xx, inclusive, of the general statutes, as amended by this act, as applicable, and such sponsored captive insurance company's plan of operation approved by the commissioner, without affecting such converted protected cell's or incorporated protected cell's assets, rights, benefits, obligations and liabilities.

(b) Any conversion of a protected cell or incorporated protected cell shall be deemed to be a continuation of such protected cell's or incorporated protected cell's existence together with all of such protected cell's or incorporated protected cell's assets, rights, benefits, obligations and liabilities, as (1) a new protected cell or incorporated protected cell, (2) a sponsored captive insurance company, (3) a sponsored captive insurance company licensed as a special purpose financial captive insurance company, (4) a pure captive insurance company, (5) a risk retention group, (6) an industrial insured captive insurance company, or (7) an association captive insurance company, as applicable. Any such conversion of a protected cell or incorporated

protected cell shall be deemed to occur without any transfer or assignment of such cell's assets, rights, benefits, obligations or liabilities, and without the creation of any reversionary interest in, or impairment of, any such assets, rights, benefits, obligations or liabilities.

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

(d) Any protected cell or incorporated protected cell that converts into an incorporated protected cell, a new captive insurance company or risk retention group, in accordance with the provisions of this section, shall perform such conversion in accordance with chapter 601 or 613 of the general statutes, as applicable, or in accordance with any such provisions of the general statutes applicable to the formation of any other type of legal entity permissible under the laws of this state, as applicable.

Sec. 16. Section 38a-556a of the general statutes is repealed. (*Effective from passage*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2024*	38a-8
Sec. 2	*October 1, 2024*	38a-16
Sec. 3	*October 1, 2024*	38a-790(a)
Sec. 4	*October 1, 2024*	38a-792(a)
Sec. 5	*October 1, 2024*	38a-48
Sec. 6	*October 1, 2024*	38a-53(a)
Sec. 7	*October 1, 2024*	38a-54(a)
Sec. 8	*October 1, 2024*	38a-297
Sec. 9	*January 1, 2025*	38a-479ppp
Sec. 10	*from passage*	38a-556

Sec. 11	*October 1, 2024*	38a-564(4)
Sec. 12	*October 1, 2024*	38a-614(1)
Sec. 13	*October 1, 2024*	38a-591l(b)
Sec. 14	*October 1, 2024*	38a-91aa
Sec. 15	*October 1, 2024*	New section
Sec. 16	*from passage*	Repealer section

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 25 $	FY 26 $
Insurance Dept.	GF - Potential Revenue Gain	Minimal	Minimal
Insurance Dept.	GF - Revenue Impact	-2.4 million	2.4 million
Department of Revenue Services	GF - Potential Revenue Gain	Minimal	Minimal

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill makes various unrelated changes to the insurance statutes, resulting in the fiscal impacts below.

Section 1 allows for a penalty of up to $100,000 to be enforced, which may result in a revenue gain to the General Fund; however, the potential revenue gain is anticipated to be minimal because fines imposed by the Insurance Department (DOI) under current law are typically paid without the type of legal action permitted by the bill.

Sections 3 and 4 change the license renewal timing for motor vehicle physical damage appraisers and casualty claims adjusters, which is anticipated to shift approximately $2.4 million in General Fund renewal fee revenue from FY 25 to FY 26 (and from odd to even numbered years in the out years to the extent at least the same number of licensees continue to renew). The revenue shift associated with existing licensees

that continue to renew is estimated to be approximately $2.4 million.[1] The amount of shift associated with new licensees will depend on the timing of their birthdates and initial licensures.

Licensees currently pay DOI the $80 renewal fee for the period ending June 30th in each odd-numbered year (e.g., 2025). Under the bill, new initial licensees after October 1, 2024 will pay the renewal fee on their birthday every other year. DOI intends to shift all licensees to the birthday-date expiration schedule, which the department has the discretion to do under the bill, with existing licensees renewing in the 12 months following October 1, 2024. This will result in renewal fee revenue from the $80 renewal fee being incurred more evenly between odd and even numbered years and does not change the amount of license fee revenue the Insurance Department collects over a two-year period.

Sections 14 and 15 allow sponsored captive insurance companies to convert a protected cell into a new captive insurance company or certain other entities. This may attract new captives to Connecticut or lead existing protected cells to become separate captives. To the extent this flexibility for captives leads additional captives to be established in the state, the bill could result in a General Fund revenue gain beginning as early as FY 25 to DOI, for each new captive, from: (1) application and formation fees of $1,050, (2) a fee for initial license of $375, and (3) annual license renewal fees in subsequent fiscal years of $375.[2] To the extent new captives are established, the section may also result in a revenue gain to the General Fund from insurance premium taxes beginning in FY 25.

According to DOI there are currently 24 protected cells within

[1]According to the Insurance Department, there are currently 5,874 licensed motor vehicle physical damage appraisers and 116,392 licensed casualty claims adjusters. Under current law, fee revenue will total approximately $9.8 million in FY 25 if all licensees renew. Under the bill, 25% of existing licensees are assumed to pay renewal fees based on birthdays between July 1, 2025 and September 30, 2025, with that $2.4 million in fee revenue being paid in FY 26.

[2]According to DOI, there are 42 captive insurance companies fully licensed and currently writing business in Connecticut.

sponsored captives. To the extent existing protected cells are converted into new captives, there will be a minimal General Fund revenue gain to DOI associated with those entities paying separate $375 license fees annually. A converted captive would not pay an initial application fee.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation, the timing of applications and renewals of motor vehicle physical damage appraiser and casualty claims adjuster licenses, and the amount of any new captive insurers established and their written premiums.

OLR Bill Analysis

sHB 5503

AN ACT CONCERNING INSURANCE MARKET CONDUCT AND INSURANCE LICENSING, THE INSURANCE DEPARTMENT'S TECHNICAL CORRECTIONS AND OTHER REVISIONS TO THE INSURANCE STATUTES AND CAPTIVE INSURANCE.

TABLE OF CONTENTS:

§ 8 — NON-ENGLISH INSURANCE DOCUMENTS AND TRANSLATIONS

Requires insurers who file policies in a non-English language to certify that they comply with readable language requirements and bear the risks associated with any translations; allows the insurance commissioner to hire translation services at the insurer's cost

§ 9 — PHARMACY BENEFIT MANAGER REPORT DUE DATE

Moves up the annual due date for PBMs to report rebate information to the insurance commissioner by one month; requires the commissioner to give the PBMs a copy of his annual report to the Insurance and Real Estate Committee by 10 days before it is due to the committee

§§ 10 & 16 — CONNECTICUT CLEARINGHOUSE REPEALED

Repeals a requirement that the Health Reinsurance Association develop the Connecticut Clearinghouse on health insurance policies available in the state

§ 11 — SMALL EMPLOYER DEFINITION

Beginning January 1, 2025, updates the definition of "small employer" in the health insurance statutes to mean having no more than 50 employees

§ 13 — INDEPENDENT REVIEW ORGANIZATION ACCREDITATION PERIOD

Extends the accreditation approval or reapproval period for independent review organizations from two to three years

§§ 14 & 15 — CAPTIVE INSURER CONVERSION OF PROTECTED CELLS

Allows a captive insurer's protected cell to convert into a new protected cell, incorporated cell, or captive insurance company without any impact on the protected cell's assets, rights, benefits, obligations, and liabilities

BACKGROUND

SUMMARY

This bill makes numerous unrelated changes to insurance statutes, as summarized in the section-by-section analysis below.

EFFECTIVE DATE: October 1, 2024, unless otherwise stated below.

§ 1 — INSURANCE COMMISSIONER'S ENFORCEMENT AUTHORITY

Allows the insurance commissioner to impose restitution, with interest, when someone violates the state's insurance laws, regulations, or commissioner orders; allows the commissioner to ask the attorney general to file a court action to enforce the laws, regulations, or commissioner orders, impose a fine of up to $100,000 per violation, or order restitution with interest

By law, the insurance commissioner must administer and enforce the laws regarding insurance companies and health care centers (i.e., HMOs). Relatedly, the law grants him the reasonable and necessary powers to protect the public interest.

The bill explicitly allows the commissioner to order restitution of any amount obtained in violation of the state's insurance laws, regulations, or commissioner orders, plus interest as allowed under another state law. This is generally 10% interest per year (CGS § 37-3a).

Additionally, whenever the commissioner finds and can show that a person has violated, or is about to violate, the state's insurance laws, regulations, or commissioner orders, the bill allows him to ask the attorney general to bring an action in Hartford Superior Court for an injunction (permanent or temporary), restraining order, or other appropriate order; a penalty of up to $100,000 per violation; or restitution, with interest, for the amount the person obtained in violation of the laws, regulations, or commissioner orders. The commissioner is not required to post a bond in any court action brought. And if the commissioner prevails in court, the court may also order the state's costs be paid as part of its order. (Under existing law, the commissioner may already request the attorney general to apply to Superior Court for a permanent or temporary order restraining a person from violating the insurance laws (CGS § 38a-16(b)).)

§ 2 — 30 DAYS TO TURN OVER DOCUMENTS

Requires anyone requested to provide the Insurance Department with documents related to an investigation to comply within 30 days after the request

By law, the insurance commissioner may conduct investigations and hearings on any matter under the insurance laws. He may, among other things, order the production of books, records, papers, or documents for

an investigation.

The bill requires that anyone who receives a request for the production of books, records, papers, or documents comply with the order within 30 days after the date of the order. By law, if a person refuses to comply, the commissioner may ask the Superior Court to order compliance.

§§ 3 & 4 — EXPIRATION DATE FOR CERTAIN INITIAL LICENSES

Revises the expiration date for initial licenses issued to motor vehicle damage appraisers and casualty claims adjusters from June 30 in an odd-numbered year to two years after the licensee's birthday that came before the license was issued

Under current law, initial licenses for motor vehicle damage appraisers and casualty claim adjusters expire on the June 30 in an odd-numbered year following the license issuance, unless sooner revoked or suspended. The bill changes this expiration date to be two years after the licensee's birthday that came before the date the license was issued, unless it was already revoked or suspended. By law, a licensee may renew the license every two years at the insurance commissioner's discretion with payment of the required renewal fees.

§ 5 — GENERAL INSURANCE ASSESSMENT PROCESS

Removes the Office of the Healthcare Advocate from the Insurance Department's annual process of assessing carriers for the general insurance assessment

By law, domestic insurers and HMOs pay an annual assessment to the Insurance Department to cover the expenses of the Insurance Department, Office of the Healthcare Advocate, and Office of Health Strategy, among other things.

Under current law, the insurance commissioner and the Office of the Healthcare Advocate assess the entities following a process set in state law. The bill removes the Office of the Healthcare Advocate from this process, leaving the insurance commissioner to manage the assessment process.

It also makes technical and conforming changes.

§§ 6, 7 & 12 — ELECTRONIC FILINGS IN LIEU OF PAPER FILINGS

Removes requirements that insurers file copies of annual financial statements and audited financial reports with the insurance commissioner, allowing electronic filings to the NAIC to suffice

Current law requires domestic insurers, HMOs, and fraternal benefit societies to file copies of annual financial statements and audited financial reports with the insurance commissioner as well as electronically with the National Association of Insurance Commissioners (NAIC). The bill eliminates the requirement to submit these to the commissioner. Instead, it deems the companies' electronic submissions to the NAIC, as required by law, to have been filed with the commissioner.

§ 8 — NON-ENGLISH INSURANCE DOCUMENTS AND TRANSLATIONS

Requires insurers who file policies in a non-English language to certify that they comply with readable language requirements and bear the risks associated with any translations; allows the insurance commissioner to hire translation services at the insurer's cost

By law, insurance policies filed with the Insurance Department must meet certain readability standards (e.g., Flesch reading ease scores and print specifications). As under current law, the bill allows insurers to file policies in any language. The insurer must certify that the policy complies with the readability standards or is translated from a policy that complies.

The bill allows the insurance commissioner to hire a translation service to review a non-English-language policy filed by an insurer. The insurer that filed the policy must pay the cost of the translation. Alternatively, the commissioner may require the insurer to provide an English translated copy of the policy and a certification as to the accuracy of the translation. The bill requires the insurer to accept all risk associated with a translation.

The bill also allows the commissioner to adopt implementing regulations.

§ 9 — PHARMACY BENEFIT MANAGER REPORT DUE DATE

Moves up the annual due date for PBMs to report rebate information to the insurance commissioner by one month; requires the commissioner to give the PBMs a copy of his

annual report to the Insurance and Real Estate Committee by 10 days before it is due to the committee

By law, each pharmacy benefit manager (PBM) must file a report annually with the insurance commissioner concerning prescription drug rebates. Under current law, the report is due by March 1. The bill moves up the due date to February 1, beginning in 2025.

The law also requires the commissioner to report to the Insurance and Real Estate Committee, annually by March 1, an aggregation of the PBMs' rebate reports. Under current law, the commissioner must give the PBMs an advanced copy of this report by February 1 annually. The bill instead requires him to give them the advanced copy by 10 days before he reports to the committee.

EFFECTIVE DATE: January 1, 2025

§§ 10 & 16 — CONNECTICUT CLEARINGHOUSE REPEALED

Repeals a requirement that the Health Reinsurance Association develop the Connecticut Clearinghouse on health insurance policies available in the state

Current law requires the Health Reinsurance Association to develop the Connecticut Clearinghouse as a resource for individuals and small employers to get information on health insurance policies and plans available in the state. The bill repeals this requirement. (The clearinghouse has largely been replaced by the health insurance exchange, Access Health CT.)

EFFECTIVE DATE: Upon passage

§ 11 — SMALL EMPLOYER DEFINITION

Beginning January 1, 2025, updates the definition of "small employer" in the health insurance statutes to mean having no more than 50 employees

Beginning January 1, 2025, the bill defines "small employer" for purposes of the health insurance laws to mean an employer with an average of at least one and no more than 50 employees on business days in the prior calendar year and at least one employee on the first day of the group health insurance plan year.

Current law extends the definition to no more than 100 employees,

except that the insurance commissioner may postpone that definition to be consistent with the federal Affordable Care Act. The commissioner did that in Insurance Bulletin HC-106 (2015). So, in practice, the small employer definition has been no more than 50 employees since before 2016.

The bill removes the commissioner's authority to postpone the change in definition. As a result, under the bill, from October 1, 2024, to December 31, 2024, a small employer is one that has no more than 100 employees. This means plans covering between 50 and 100 employees must comply with the laws affecting small employers for a three-month period (e.g., rating requirements, mandatory benefits).

§ 13 — INDEPENDENT REVIEW ORGANIZATION ACCREDITATION PERIOD

Extends the accreditation approval or reapproval period for independent review organizations from two to three years

By law, the insurance commissioner maintains a list of accredited independent review organizations that are available to conduct regular or expedited external reviews of health insurance grievances. Under current law, an accreditation lasts two years. The bill extends this to three years. As under existing law, if the commissioner determines that an organization no longer meets the minimum requirements for accreditation, he must end its approval and remove it from the list of approved organizations.

§§ 14 & 15 — CAPTIVE INSURER CONVERSION OF PROTECTED CELLS

Allows a captive insurer's protected cell to convert into a new protected cell, incorporated cell, or captive insurance company without any impact on the protected cell's assets, rights, benefits, obligations, and liabilities

Captive Insurer

Generally, a captive insurer is an insurance company formed to insure or reinsure the risks of its owners, parent company, or affiliated company. The law allows several different types of captive insurers to be licensed and operate in the state, including a sponsored captive insurer.

A sponsored captive insurer is an insurance company (1) for which one or more sponsors provide the minimum paid-in capital and surplus, (2) that insures its participants through separate participant contracts, and (3) that funds its liability to each participant through protected cells and separates each cell's assets from that of other cells and the captive insurer as a whole. PA 23-15 allowed these protected cells to establish, with the insurance commissioner's prior written approval, separate accounts and allocate assets to them, subject to certain requirements.

Conversion of Protected Cell Allowed

The bill allows sponsored captive insurers to convert protected or incorporated protected cells into one of the following other insurance company structures or types of accounts:

1. a single protected or incorporated protected cell;
2. a new sponsored captive insurer (including those licensed as a special purpose financial captive insurer);
3. a new special purpose financial captive, pure captive, agency captive, industrial insured captive, or association captive insurer; or
4. a new risk retention group.

Any conversion is deemed to (1) be a continuation of the cell's existence, with all of its assets, rights, benefits, obligations, and liabilities, and (2) occur without any transfer or assignment of these assets, rights, benefits, obligations, and liabilities and without creating any reversionary interest in or impairment of them. The bill specifies that the conversion does not limit any rights or protections applicable to the cell or the sponsored captive that existed prior to the conversion.

Conversion Process

Under the bill, a sponsored captive must apply to the insurance commissioner and receive his prior written approval for the conversion. Additionally, the bill subjects the conversion to the existing laws

regulating captives and the sponsored captive insurer's plan of operation approved by the commissioner, without affecting the converted cell's assets, rights, benefits, obligations, and liabilities.

For cells that convert into an incorporated protected cell or a new captive insurer or risk retention group, the conversion must follow all existing business corporation or limited liability company laws that are applicable to the newly formed business or legal entity.

BACKGROUND

Legislative History

The House referred the bill (File 378) to the Insurance and Real Estate Committee, which reported a substitute that replaced the underlying bill's study of workforce shortages and workforce development with various insurance-related provisions.

Related Bill

SB 372 (File 570), favorably reported by the Appropriations Committee, among other things, limits the type of domestic insurance entities required to pay the portion of the general insurance assessment that supports the budgets of the Office of the Healthcare Advocate and the Office of Health Strategy.

COMMITTEE ACTION

Commerce Committee

Joint Favorable
Yea 21 Nay 3 (03/21/2024)

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 12 Nay 0 (04/23/2024)