Agency Legislative Proposal - 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **DRAFT CID 2017 AA Fostering the Domestic Insurance Industry**

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

State Agency: Connecticut Insurance Department
Liaison: Eric Weinstein **Phone:** 860/297-3864 **E-mail:** Eric.Weinstein@ct.gov
Lead agency division requesting this proposal: §§ 1-4: Financial Regulation § 5: Captive §§ 6 & 7: Legal and Licensing
Agency Analyst/Drafter of Proposal: §§ 1-4: Jon Arsenault § 5: Janet Grace, Ralph Chin §§ 6 & 7: Jon Arsenault

Title of Proposal: AA Fostering the Domestic Insurance Industry
Statutory Reference: §§ 1-4: Conn. Gen. Stat. §§ 38a-85 to 38a-89, inclusive. § 5: Conn. Gen. Stat. §38a-91dd §§ 6 & 7: Conn. Gen. Stat. §§ 38a-1, 38a-743, and 38a-794
Proposal Summary: • ***Sections 1-4: Credit for Reinsurance*** • ***Section 5: Minimum Capital and Surplus Requirements for Captives*** • ***Sections 6&7: Designation as a Surplus Lines Insurer*** ***Sections 1-4: Credit for Reinsurance*** **<u>Sections 1 thru 3</u>** will amend Conn. Gen. Stat. §§ 38a-85(a), 38a-86, and 38a-88 to adopt the January 2016 revisions to the National Association of Insurance Commissioners Credit for Reinsurance Model Law to give authority to adopt regulations relating to (1) the valuation of assets or reserve credits, (2) the amount and forms of security supporting reinsurance

arrangements relating to certain specified reinsurance arrangements, and or (3) the circumstances pursuant to which credit will be reduced or eliminated.

Promulgation of the regulation contemplated by this revised legislation is expected to establish uniform, national standards governing reserve financing arrangements pertaining to life insurance policies containing guaranteed nonlevel gross premiums, guaranteed nonlevel benefits and universal life insurance policies with secondary guarantees. Such regulation would replace an existing actuarial guideline and will ensure that, with respect to each such financing arrangement, funds consisting of security as defined in the regulation, are held by or on behalf of ceding insurers in the forms and amounts required therein.

Section 4 will make a technical change to Conn. Gen. Stat. § 38a-73 concerning the 10% maximum (net) exposure to any one risk as it relates to calculation of the threshold and the reduction for portions of risk reinsured, to replace the words "authorized to do business in this state" with "that meets the requirements of section 38a-85 or section 38a-86."

Section 5: Minimum Capital and Surplus Requirements for Captives

Section 5 Reduces Connecticut's minimum capital requirement for a captive from $500,000 to $225,000 to remain competitive and attract more captive entities to domicile in Connecticut.

Sections 6&7: Designation as a Surplus Lines Insurer

Section 6 amends Conn. Gen. Stat. § 38a-1 definitions of "alien insurer", "domestic insurer", "foreign insurer", "unauthorized insurer" and adds a new definition of "domestic surplus lines insurer".

Section 7 (NEW) (a) allows a domestic insurer that possesses minimum capital and surplus of at least $15 million, pursuant to resolution by the insurer's board of directors and upon approval of the Commissioner, to be designated as a domestic surplus lines insurer and be considered an unauthorized insurer for the purposes of writing surplus lines insurance.
(b) restricts a domestic surplus lines insurer to only writing surplus lines insurer in Connecticut and allows the insurer to write surplus lines in any other jurisdiction where the insurer complies with the jurisdiction's requirements.
(c) specifies that insurance written by a domestic surplus lines insurer is subject to the premium tax on surplus lines and is exempt from the premium tax under Conn. Gen. Stat. § 12-202.
(d) specifies that a domestic surplus lines insurer shall be considered a nonadmitted insurer for purposes of the federal Nonadmitted and Reinsurance Reform Act of 2010 (15 U.S.C. § 8206).

(e) and (f) specifies that surplus lines insurance policies issued by a domestic surplus lines insurer in this state are not subject to the protection of the Connecticut Insurance Guaranty Association, and are exempt from statutory requirements relating to insurance rating and rating plans, policy forms, policy cancellation and nonrenewal in the same manner and extent as for policies from surplus lines insurers domiciled in another state.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

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

(2) *Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?* ***Sections 1-4:*** **Yes, states are enacting legislation to adopt this NAIC recommended legislation. Section 5: Vermont reduced their minimum capital surplus requirement from $500,000 to $250,000 during their 2015 legislative session. Sections 6 and 7: Ten jurisdictions allow domestic insurers to sell surplus lines insurance in their state of domicile.**

(3) *Have certain constituencies called for this action?* **Sections 1-4: Yes, state insurance regulators throughout the U.S. Section 5: The Connecticut Captive Insurance Association would be supportive. Sections 6 and 7: Yes. The Property Casualty Insurers Association of America is among those interested in passage of legislation similar to Sections 6 and 7 of this proposal.**

(4) *What would happen if this was not enacted in law this session?* **Sections 6 and 7: One or more insurers domiciled in this state may perceive that there is an advantage in becoming domiciled in another state that authorizes a domestic surplus lines insurer. CID would likely pursue the same concepts again.**

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◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

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

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

(3) *Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation? What was the last action taken during the past legislative session?*

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

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Department of Revenue Services (Sections 6 and 7) **Agency Contact (*name, title, phone*):** Susan Sherman, Legislative Program Manager 860/297-5693 **Date Contacted:** 12/19/16 Approve of Proposal ☐ **YES** ☐ **NO** ☒ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
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 Sections 1-4: None Section 5: The change is intended to license more captive insurance companies in the state, in which case there would be additional premium tax revenue for the associated risk premiums. Sections 6 and 7: Currently, a domestic insurer operating as a surplus lines insurer in other states, would be subject to the 1.75% tax on all net direct insurance premiums imposed by Conn. Gen. Stat. § 12-202 on policies written on property or risks located or resident in this state. This legislation specifies that insurance written by a domestic surplus lines insurer is subject to the 4.0% tax payable by surplus lines brokers on the gross premiums charged insureds by nonadmitted insurers when Connecticut is the "home state" of such insureds, pursuant to Conn. Gen. Stat. § 38a-743.
Federal None
Additional notes on fiscal impact Click here to enter text.

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

Sections 1 thru 4 Adopt the 2016 revisions to the NAIC Credit for Reinsurance Model Law to give the Department the authority to adopt regulations relating to:

1. The valuation of assets or reserve credits,
2. The amount and forms of security supporting reinsurance arrangements relating to certain specified reinsurance arrangements entered into with life/health insurer-affiliated captives, special purpose vehicles or similar entities that may not have the same statutory accounting requirements or solvency requirements as US-based multi-state life/health insurers, and
3. The circumstances pursuant to which credit will be reduced or eliminated.

Section 5: Connecticut's minimum capital requirement is higher than most other states thus making the creation of these companies not competitive. Creation of the company bears no risk; as cells are added risk based surplus is required and unit procedures can accommodate changes in the risk profile with the addition of each cell. Connecticut had parity with Vermont, a leader in the captive space, with a $500,000 minimum capital requirement, but Vermont reduced their requirement from $500,000 to $250,000 in 2015. Reducing the capital requirement in Connecticut to $225,000, lower than Vermont, would signal to the market that Connecticut is highly competitive and is the State to domicile their captive entity.

Sections 6 and 7 will allow more companies to domicile in the state:

Section 6 amends the definitions of "alien insurer", "domestic insurer", "foreign insurer", "unauthorized insurer" and adds a new definition of "domestic surplus lines insurer".

Section 7 allows a domestic insurer that possesses minimum capital and surplus of at least $15 million, pursuant to resolution by the insurer's board of directors and upon approval of the Commissioner, to be designated as a domestic surplus lines insurer and be considered an unauthorized insurer for the purposes of writing surplus lines insurance.
(b) restricts a domestic surplus lines insurer to only writing surplus lines insurer in Connecticut and allows the insurer to write surplus lines in any other jurisdiction where the insurer complies with the jurisdiction's requirements.
(c) specifies that insurance written by a domestic surplus lines insurer is subject to the premium tax on surplus lines and is exempt from the premium tax under Conn. Gen. Stat. § 12-202.
(d) specifies that a domestic surplus lines insurer shall be considered a nonadmitted insurer for purposes of the federal Nonadmitted and Reinsurance Reform Act of 2010 (15 U.S.C. § 8206).
(e) and (f) specifies that surplus lines insurance policies issued by a domestic surplus lines insurer in this state are not subject to the protection of the Connecticut Insurance Guaranty Association, and are exempt from statutory requirements relating to insurance rating and

rating plans, policy forms, policy cancellation and nonrenewal in the same manner and extent as for policies from surplus lines insurers domiciled in another state.

Insert fully drafted bill here

Section 1. Subsection (a) of section 38a-85 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of:

(1) Subsection (b) of this section;

(2) Subsection (c) of this section;

(3) Subsections (d) and (h) of this section;

(4) Subsections (e), (h) and (i) of this section;

(5) Subsections (f) and (i) of this section; or

(6) Subsection (g) of this section;

provided further, that the commissioner may adopt by regulation pursuant to subsection (b) of section 38a-88, as amended by this act, specific additional requirements relating to or setting forth: (A) the valuation of assets or reserve credits; (B) the amount and forms of security supporting reinsurance arrangements described in subsection (b) of section 38a-88; and/or (3) the circumstances pursuant to which credit will be reduced or eliminated.

Sec. 2. Sec. 38a-86 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

A credit for an asset or a reduction in liability shall be allowed for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of section 38a-85, in an amount not exceeding the liabilities carried by the ceding insurer; provided further, that the Commissioner may adopt by regulation pursuant to subsection (b) of section 38a-88, as amended by this act, specific additional requirements relating to or setting forth: (A) the valuation of assets or reserve credits; (B) the amount and forms of security supporting reinsurance arrangements described in subsection (b) of section 38a-88; and/or (3) the circumstances pursuant to which credit will be reduced or eliminated. Such credit or reduction shall be in the amount of funds held by or on behalf of the ceding insurer,

including funds held in trust for the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder, if such security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified United States financial institution, as defined in section 38a-87. Such security may be in the form of (1) cash, (2) securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those deemed exempt from filing by the Purposes and Procedures Manual of said office, and qualifying as admitted assets, (3) clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified institution, that is effective not later than December thirty-first of the year for which filing is being made, and in the possession of or in trust for the ceding insurer on or before the filing date of its annual statement, provided letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs. As used in this subdivision, "qualified institution" means an institution that (A) is organized or, in the case of a United States office of a foreign banking organization, licensed, under the laws of the United States or any state thereof, (B) is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies, and (C) has been determined by the commissioner or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner, or (4) any other form of security acceptable to the commissioner.

Sec. 3. Section 38a-88 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 to implement the provisions of sections 38a-85 to 38a-89, inclusive.

(b) The commissioner is further authorized to adopt regulations applicable to reinsurance arrangements described in subdivision (1) of this subsection.

(1) A regulation adopted pursuant to this subsection, may apply only to reinsurance relating to: (A) Life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits; (B) Universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period; (C) Variable annuities with guaranteed death or living benefits; (D) Long-term care insurance policies; or (E) Such other life and health insurance and annuity products as to which the NAIC adopts model regulatory requirements with respect to credit for reinsurance.

(2) A regulation adopted pursuant to subparagraphs (A) or (B) of subdivision 1 of this subsection, may apply to any treaty containing (A) policies issued on or after January 1, 2015, and/or

(B) policies issued prior to January 1, 2015, if risk pertaining to such pre-2015 policies is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015.

(3) A regulation adopted pursuant to this subsection may require the ceding insurer, in calculating the amounts or forms of security required to be held under regulations promulgated under this authority, to use the Valuation Manual as defined in section 38a-78 in effect on the date as of which the calculation is made, to the extent applicable.

(4) A regulation adopted pursuant to this subsection shall not apply to cessions to an assuming insurer that:

(A) Is certified in this state; or

(B) Maintains at least $250 million in capital and surplus when determined in accordance with the National Association of Insurance Commissioners' *Accounting Practices and Procedures Manual*, including all amendments thereto adopted by the National Association of Insurance Commissioners, excluding the impact of any permitted or prescribed practices; and is (i) licensed in at least 26 states; or (ii) licensed in at least 10 states, and licensed or accredited in a total of at least 35 states.

(5) The authority to adopt regulations pursuant to this subsection does not limit the commissioner's general authority to adopt regulations pursuant to subsection (a) of this section.

Sec. 4. Sec. 38a-73 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):
No stock insurance company doing business in this state shall expose itself to loss on any one risk to an amount exceeding ten per cent of its paid-up capital and surplus; but, in determining the amount of such risk, no portion thereof which has been reinsured in any insurance company [authorized to do business in this state] that meets the requirements of section 38a-85 or section 38a-86 shall be included. No mutual insurance company doing business in this state shall expose itself to loss on any one risk to an amount exceeding ten per cent of its net surplus which limit on any one risk shall, in no case, exceed the amount authorized by the charter, bylaws or board of directors of the company; but, in determining the amount of such risk, no portion thereof which has been reinsured in any insurance company [authorized to do business in this state] that meets the requirements of section 38a-85 or section 38a-86 shall be included.

Sec 5. Section 38a-91dd of the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2017):
Sec. 38a-91dd. Capital and surplus requirements. (a)(1) The Insurance Commissioner shall not issue a license to a captive insurance company or allow the company to retain such license unless the company has and maintains unimpaired paid-in capital and surplus of:

(A) In the case of a pure captive insurance company, not less than two hundred fifty thousand dollars;

(B) In the case of an association captive insurance company, not less than five hundred thousand dollars;

(C) In the case of an industrial insured captive insurance company, not less than five hundred thousand dollars;

(D) In the case of a risk retention group, not less than one million dollars;

(E) In the case of a sponsored captive insurance company, not less than five hundred thousand dollars;

(F) In the case of a special purpose financial captive insurance company, not less than two hundred fifty thousand dollars; and

(G) In the case of a sponsored captive insurance company licensed as a special purpose financial captive insurance company, not less than **[**five hundred**]** two hundred and twenty five thousand dollars.

(2) (A) The Insurance Commissioner shall not issue a license to a branch captive insurance company or allow the company to retain such license unless the company has and maintains, as security for the payment of liabilities attributable to the branch operations:

(i) Not less than two hundred fifty thousand dollars; and

(ii) Reserves on such insurance policies or such reinsurance contracts as may be issued or assumed by the branch captive insurance company through its branch operations, including reserves for losses, allocated loss adjustment expenses, incurred but not reported losses and unearned premiums with regard to business written through the branch operations. The commissioner may permit a branch captive insurance company to credit against any such reserves any security for loss reserves that the branch captive insurance company posts with a ceding insurer or is posted by a reinsurer with the branch captive insurance company, so long as such security remains posted.

(B) The amounts required under subparagraph (A) of this subdivision may be held, with the prior approval of the commissioner, in the form of (i) a trust formed under a trust agreement and funded by assets acceptable to the commissioner, (ii) an irrevocable letter of credit issued or confirmed by a bank approved by the commissioner, (iii) with respect to the amount required under subparagraph (A)(i) of this subdivision only, cash on deposit with the commissioner, or (iv) any combination thereof.

(b) The commissioner may adopt regulations, in accordance with chapter 54, to establish additional capital and surplus requirements based upon the type, volume and nature of insurance business transacted.

(c) Except as specified in subdivision (2) of subsection (a) of this section, capital and surplus may be in the form of cash or an irrevocable letter of credit issued by a bank approved by the commissioner.

Sec. 6. Section 38a-1 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

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

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

(2) "Alien insurer" **[**is defined in subparagraph (A) of subdivision (11) of this section**]** means any insurer that has been chartered by or organized or constituted within or under the laws of any jurisdiction or foreign country without the United States.

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

(4) "Commissioner" means the Insurance Commissioner.

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

(6) "Domestic insurer" **[**is defined in subparagraph (B) of subdivision (11) of this section**]** means any insurer that has been chartered by, incorporated, organized or constituted within or under the laws of this state.

(7) "Domestic surplus lines insurer" means any domestic insurer that has been authorized to be an eligible surplus lines insurer by the commissioner.

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

[(8)**]** (9) "Foreign insurer" **[**is defined in subparagraph (C) of subdivision (11) of this section**]** means any insurer that has been chartered by or organized or constituted within or under the laws of another state or a territory of the United States.

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

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

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

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

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

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

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

(E) "Unauthorized insurer" or "nonadmitted insurer" means an insurer that has not been granted a certificate of authority by the commissioner to transact the business of insurance in this state or an insurer transacting business not authorized by a valid certificate.**]**

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

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

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

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

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

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

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

[(18)**]** (20) "Unauthorized insurer" **[**is defined in subparagraph (E) of subdivision (11) of this section**]** or "nonadmitted insurer" means an insurer that has not been granted a certificate of authority by the commissioner to transact the business of insurance in this state or an insurer transacting business not authorized by a valid certificate.

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

Sec. 7. (NEW) (*Effective July 1, 2017*):

(a) A domestic insurer possessing policyholder surplus of at least fifteen million dollars may, pursuant to resolution by its board of directors, and with the approval of the Insurance Commissioner, be designated as a domestic surplus lines insurer. A domestic surplus lines insurer shall be considered an unauthorized insurer for purposes of writing surplus lines insurance coverage.

(b) A domestic surplus lines insurer shall only write surplus lines insurance in this state procured pursuant to the requirements of chapter 701d and section 38a-794. A domestic surplus lines insurer may write surplus lines insurance in any other jurisdiction in which the insurer is eligible to write surplus lines insurance if any other jurisdiction in which the insurer is eligible to write surplus lines insurance if the domestic surplus lines insurer complies with any requirements of that jurisdiction.

(c) Insurance written by a domestic surplus lines insurer shall be subject to the tax on premiums provided by section 38a-743 and is exempt from the tax on premiums required by section 12-202.

(d) A domestic surplus lines insurer shall be considered a nonadmitted insurer as referenced in 15 U.S. Code section 8206 with respect to surplus lines insurance issued in this state.

(e) Surplus lines insurance policies issued by a domestic surplus lines insurer in this state are not subject to the protection of or other provisions of the Connecticut Insurance Guaranty Association established by section 38a-839.

(f) Surplus lines insurance policies issued in this state by a domestic surplus lines insurer are not subject to and are exempt from all statutory requirements relating to insurance rating and rating plans, policy forms, policy cancellation and nonrenewal in the same manner and to the same extent as a surplus lines insurer domiciled in another state.

Agency Legislative Proposal - 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **DRAFT CID 2017 AAC Consumer Choices and Protections in Insurance**

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

State Agency: Connecticut Insurance Department
Liaison: Eric Weinstein **Phone:** 860/297-3864 **E-mail:** Eric.Weinstein@ct.gov
Lead agency division requesting this proposal: §§ 1 & 2: Life and Health §§ 3 – 6: Legal § 7: Property and Casualty
Agency Analyst/Drafter of Proposal: §§ 1 & 2: Kristin Campanelli, Mary Ellen Breault §§ 3 – 6: Jon Arsenault § 7: George Bradner

Title of Proposal: AAC Consumer Choices and Protections in Insurance
Statutory Reference: § 1: NEW § 2: Conn. Gen. Stat. §38a-177 §§ 3 – 6: New section to be codified in Chapter 704c; Conn. Gen. Stat. §§ 38a-930, 38a-140(b), and 38a-18 § 7: Conn. Gen. Stat. §38a-323
Proposal Summary: • ***Section 1: Short Term Care Insurance for Group Policies*** • ***Section 2: HMO Coinsurance*** • ***Sections 3-6: The Insurers Rehabilitation and Liquidation Act*** • ***Section 7: Renewal Notifications for Commercial and Personal Business*** ***Section 1: Short Term Care Insurance for Group Policies*** **Section 1:** This section expands the short term care coverage from just individual plans to group plans.

Section 2: HMO Coinsurance

Section 2: This would allow HMOs to charge coinsurance. This would provide consumers with more options in the market that have lower premiums.

Sections 3-6: The Insurers Rehabilitation and Liquidation Act

Sections 3-6 are 2015 HB 5232: AAC The Insurers Rehabilitation and Liquidation Act, File Copy #174

Passage of this bill would put Connecticut in compliance with the process mandated by the Dodd-Frank Act in overseeing the liquidation or "run-off" of insurance companies. This would amend Connecticut's insurance receivership statutes to conform to the Dodd-Frank Act and also cleans up other related statutes. This will make Connecticut more prepared to implement receivership orders under Dodd-Frank for certain qualifying insurance companies.

Section 3: Authorizes the Insurance Commissioner to petition the Superior Court for the entry of an order of rehabilitation or liquidation for a domestic insurer that is subject to Title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203 (the "Dodd-Frank Act"). Such petitions are deem granted no later than 24 hours after filing by the Commissioner.

Section 4: Amends Conn. Gen. Stat. § 38a-930 concerning voidable transfers, to exempt from its provisions 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.

Section 5: A technical change is made to Conn. Gen. Stat. § 38a-140(b), to replace the reference to Conn. Gen. Stat. § 38a-18 (which is repealed by Section 4 of this bill) with a general reference to the chapter governing insurance receivership proceedings.

Section 6: Repeals Conn. Gen. Stat. § 38a-18 (formerly Conn. Gen. Stat. § 38-9.

Section 7: Renewal Notifications for Commercial and Personal Business

Section 7: Amends Conn. Gen. Stat. § 38a-323 to capture portions of Bulletin PC-66 in statute with regard to policy changes.

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? **Section 1: PA 16-63 (2016 HB 5521) authorizes short-term care to be sold in Connecticut for individual policies only and the Department promulgated regulations that are currently going through the regulations review process. Sections 3-6: Yes.**

(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? **Section 1: Yes, Connecticut has PA 16-63 and some other states have the product. There is currently an all-state discussion being held by the NAIC on the topic. Sections 3-6: Yes: Better preparedness for implementation of receivership orders under Dodd-Frank Act resolution of systemically important insurers.**

(3) Have certain constituencies called for this action? **Sections 3-6: 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? **CID would likely pursue these concepts again.**

◊ Origin of Proposal ☒ New Proposal §§ 1, 2, 7 ☒ Resubmission §§ 3-6

If this is a resubmission, please share: **For Sections 3-6 ONLY:**

(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 died on the Senate Calendar. In 2016, HB 5232 passed the House of Representatives, but died 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 in 2015 which was reflected in House Amendment Schedule A (LCO 6833) and in 2016 HB 5232.**

(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 April 25, 2016 HB 5232 passed the House; on April 25, 2016 it was tabled for the Senate Calendar (No. 486).**

Click here to enter text.

PROPOSAL IMPACT

◊ AGENCIES AFFECTED (*please list for each affected agency*) For Sections 3-6 ONLY

Agency Name: State of Connecticut Judicial Department **Agency Contact (*name, title, phone*):** Doreen Del Bianco, Deputy Director of External Affairs, 860/462-9995 **Date Contacted:** 9/22/16 Approve of Proposal ☒ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments **Please see question 2 in the section above**
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 **Sections 3-6: No fiscal impact. The expenses of taking possession of an insurance company placed in receivership and of conducting the receivership under the supervision of the Superior Court are paid out of the property of the insurer. No State funds are implicated.**
Federal None
Additional notes on fiscal impact Click here to enter text.

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

Section 1: This would create short term care for group policies. PA 16-63 (2016 HB 5521) authorized short term care policies to be sold in Connecticut, but only for individual plans. This language mirrors the individual language that exists in PA 16-63. Like PA 16-63, this would require the Commissioner to adopt regulations to implement this law. This will provide more options for consumers and more options that have a lower cost that could help provide coverage options. **Section 2:** Allowing HMOs to charge coinsurance would provide consumers with more options in the market that have lower premiums.

Section 3: Authorizes the Insurance Commissioner to petition the Superior Court for the entry of an order of rehabilitation or liquidation for a domestic insurer that is subject to Title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203 (the "Dodd-Frank Act"). Such petitions are deem granted no later than 24 hours after filing by the Commissioner. **Reason for Proposal:** 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 (NAIC) 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.

Section 4: Amends Conn. Gen. Stat. § 38a-930 concerning voidable transfers, to exempt from its provisions 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. **Reason for Proposal:** 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.

Section 5: A technical change is made to Conn. Gen. Stat. § 38a-140(b), to replace the reference to Conn. Gen. Stat. § 38a-18 (which is repealed by Section 4 of this bill) with a general reference to the chapter governing insurance receivership proceedings.

Section 6: Repeals Conn. Gen. Stat. § 38a-18 (formerly Conn. Gen. Stat. § 38-9). **Reason for Proposal:** This statute derives from 1902 legislation which 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.

Section 7: In order to better protect and inform consumers of changes in their deductible, or reduction in limits or coverage, the Department believes its current requirements found in Bulletin PC-66, an administrative bulletin, should be codified. This is current practice, but the directive on the industry is administrative, not statutory. Codifying these components will give the Department regulatory recourse and more oversight while also strengthening consumer protections.

Insert fully drafted bill here

Section 1. (NEW) (Effective October 1, 2017)

(a) As used in this section, "short-term care policy" means any group health insurance policy or certificate delivered or issued for delivery to any resident of this state that is designed to provide, within the terms and conditions of the policy, benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for a period not exceeding three hundred days. "Short-term care policy" does not include any such policy or certificate that is offered primarily to provide basic Medicare supplement coverage, basic medical-

surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage or limited benefit health coverage.

(b) (1) No short-term care policy or certificate shall be delivered or issued for delivery to any resident in this state, nor shall any application, rider or endorsement be used in connection with such policy or certificate, until a copy of the form thereof and of the classification of risks and the premium rates have been filed with the Insurance Commissioner. The commissioner may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to establish a procedure for reviewing such policies or certificates. The commissioner shall disapprove the use of such form at any time if the form does not conform to the requirements of law, or if the form contains a provision or provisions that are unfair or deceptive or that encourage misrepresentation of the policy or certificate. The commissioner shall notify, in writing, the insurer that has filed any such form of the commissioner's disapproval, specifying the reasons for disapproval, and ordering that no such insurer shall deliver or issue for delivery to any person in this state a policy or certificate on or containing such form. The provisions of section 38a-19 of the general statutes shall apply to such orders.
(2)No rate filed under the provisions of subdivision (1) of this subsection shall be effective until it has been approved by the commissioner in accordance with regulations adopted pursuant to this subsection. The commissioner may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to prescribe standards to ensure that such rates shall not be excessive, inadequate or unfairly discriminatory. The commissioner may disapprove such rate if it fails to comply with such standards.

(c)(1)No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center may deliver or issue for delivery any short-term care policy or certificate without providing, at the time of solicitation or application for purchase or sale of such coverage, full and fair written disclosure of the benefits and limitations of the policy or certificate.

(2)The applicant shall sign an acknowledgment at the time of application for such policy or certificate that the company, society, corporation or center has provided the written disclosure required under this subsection to the applicant. If the method of application does not allow for such signature at the time of application, the applicant shall sign such acknowledgment not later than at the time of delivery of such policy or certificate.

(3)Except for a short-term care policy or certificate for which no applicable premium rate revision or rate schedule increases can be made, such disclosure shall include:

(A) A statement in not less than twelve point bold face type that the policy or certificate does not provide long-term care insurance coverage and is not a long-term care insurance policy or certificate or a Connecticut Partnership for Long-Term Care insurance policy or certificate;

(B) A statement that the policy or certificate may be subject to rate increases in the future;

(C)An explanation of potential future premium rate revisions and the policy or certificate-holder's option in the event of a premium rate revision; and

(D)The premium rate or rate schedule applicable to the applicant that will be in effect until such company, society, corporation or center files a request with the commissioner for a revision to such premium rate or rate schedule.

(d) (1) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any short-term care policy or certificate in this state may refuse to accept, or refuse to make reimbursement pursuant to, a claim for benefits submitted by or prepared with the assistance of a managed residential community, as defined in section 19a-693 of the general statutes, in accordance with subdivision (7) of subsection (a) of section 19a-694 of the general statutes, solely because such claim for benefits was submitted by or prepared with the assistance of a managed residential community.

(2)Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center
delivering, issuing for delivery, renewing, continuing or amending any short-term care policy or certificate in this state shall, upon receipt of a written authorization executed by the insured, (A) disclose information to a managed residential community for the purpose of determining such insured's eligibility for an insurance benefit or payment, and (B) provide a copy of the initial acceptance or declination of a claim for benefits to the managed residential community at the same time such acceptance or declination is made to the insured.

(e) The commissioner may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section. Such regulations may include, but need not be limited to, (1) the permissible loss ratio for a short-term care policy or certificate, if any, (2) the permissible exclusionary periods for coverage under a short-term care policy or certificate, if any, (3) the circumstances under which a short-term care policy or certificate will be renewable, and (4) the benefits payable under a short-term care policy or certificate in relation to other insurance coverage that provides benefits to the insured.

Sec. 2. Section 38a-177 of the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2017):

Sec. 38a-177. 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**]** or (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 scientific research and learning.

Sec. 3. (NEW) (*Effective July 1, 2017*) (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. 4. Subsection (a) of section 38a-930 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(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. 5. Subsection (b) of section 38a-140 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(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. 6. Section 38a-18 of the general statutes is repealed. (*Effective July 1, 2017*)

Sec. 7. Section 38a-323 of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2017):

Sec. 38a-323. (Formerly Sec. 38-185w). Notice of nonrenewal, conditional renewal and premium billing for personal and commercial risk policies. Applicable to surplus lines insurers. Good faith effort as market conduct examination criterion. (a) No insurer shall refuse to renew any policy which is subject to the requirements of sections 38a-663 to 38a-696, inclusive, unless such insurer or its agent sends, by registered or certified mail or by mail evidenced by a certificate of mailing, or delivers to the named insured, at the address shown in the policy, at least sixty days' advance notice of its intention not to renew. The notice of intent not to renew shall state or be accompanied by a statement specifying the reason for such nonrenewal. This section shall not apply: (1) In case of nonpayment of premium; (2) if the insured fails to pay any advance premium required by the insurer for renewal, provided, notwithstanding the failure of an insurer to comply with this subsection, with respect to automobile liability insurance policies the policy shall terminate on the effective date of any other insurance policy with respect to any automobile designated in both policies; or (3) if the policy is transferred from the insurer to an affiliate of such insurer for another policy with no

interruption of coverage and contains the same terms, conditions and provisions, including policy limits, as the transferred policy, except that the insurer to which the policy is transferred shall not be prohibited from applying its rates and rating plans at the time of renewal. With respect to an automobile or homeowners policy, each insurer that sends or delivers a notice of nonrenewal pursuant to this subsection shall use the same method to send or deliver such notice to any third party designated pursuant to section 38a-323a.

(b) (1) On or after October 1, 2017, a conditional renewal notice shall be sent on any policy meeting the requirements of sections 38a-663 to 38a-696, inclusive, if an insurer intends to continue to insure a risk under terms or conditions less favorable than previously provided. The conditional renewal notice must clearly state or be accompanied by a clear statement identifying any reduction in coverage limits, coverage provisions added or revised which reduce coverage, or increases in deductible amount under the ensuing policy. The conditional renewal notice must comply with the provisions for nonrenewal in section 38a-323.

(2) **[**(1)**]** On or before September 30, 1987, a premium billing notice for any policy subject to the requirements of sections 38a-663 to 38a-696, inclusive, except a workers' compensation policy, shall be mailed or delivered to the insured by the insurer or its agent not less than forty-five days in advance of the renewal date or the anniversary date of the policy. On or after October 1, 1987, such notice shall be so mailed or delivered to the insured not less than thirty days in advance of the policy's renewal or anniversary date, except that on or after October 1, 1998, such notice shall not be required for a commercial risk policy if the premium for the ensuing policy period is to increase less than ten per cent on an annual basis. The premium billing notice shall be based on the rates and rules applicable to the ensuing policy period and shall include a notice of transfer when the policy has been transferred from an insurer to an affiliate of such insurer pursuant to the provisions of subdivision (3) of subsection (a) of this section. The provisions of this subsection shall apply to any such policy for which the annual premium was less than fifty thousand dollars for the preceding annual policy period.

(3) **[**(2)**]** For purposes of any commercial risk policy subject to the requirements of sections 38a-663 to 38a-696, inclusive, except a workers' compensation policy, the mailing or delivery of a premium billing notice by an insurer's managing general agent, in accordance with the provisions of subdivision (1) of this subsection, shall constitute compliance by such insurer with said subdivision.

(c) Failure of the insurer or its agent to provide the insured with the required notice of nonrenewal or premium billing shall entitle the insured to: (1) Renewal of the policy for a term of not less than one year, and (2) the privilege of pro-rata cancellation at the lower of the current or previous year rates if exercised by the insured within sixty days from the renewal date or anniversary date. Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal.

(d) Notwithstanding the provisions of subsection (b) of this section, the advance notice period for any premium billing notice shall be at least sixty days for any liability insurance policy wherein a municipality is the named insured.

(e) Notwithstanding the provisions of subsection (a) of this section, the advance notice period for any refusal to renew any professional liability policy shall be at least ninety days.

(f) (1) No surplus lines insurer shall be deemed eligible to write coverage for risks as provided in sections 38a-741 to 38a-744, inclusive, and 38a-794, unless such surplus lines insurer complies with the requirements of this section. (2) Notwithstanding the provisions of subsection (b) of this section, premium billing notices shall be provided by any surplus lines insurer to the insured at least sixty days in advance of the renewal or anniversary date of the policy. Notices of nonrenewal or premium billing required by this section shall be provided by the surplus lines insurer or its duly authorized representative to the insured. (3) Notwithstanding the provisions of subsection (c) of this section, failure of any surplus lines insurer to provide the insured with the required notice of nonrenewal or premium billing shall entitle the insured to an extension of the policy for a period of ninety days after the renewal or anniversary date of such policy, provided if the surplus lines insurer fails to provide the required notice on or before the renewal or anniversary date of such policy, the provisions of subsection (c) of this section shall apply. In the event of such a ninety-day extension of coverage, the premium for the extended period of coverage shall be the current rate or the previous rate, whichever is lower.

(g) For purposes of any market conduct examination performed pursuant to section 38a-15, the Insurance Commissioner may find an insurer to be in compliance with the requirements of this section upon a determination that such insurer made a good faith effort to so comply.

Agency Legislative Proposal - 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **DRAFT CID 2017 AAC Insurance Department Technical Changes**

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

State Agency: Connecticut Insurance Department
Liaison: Eric Weinstein **Phone:** 860/297-3864 **E-mail:** Eric.Weinstein@ct.gov
Lead agency division requesting this proposal: §§ 1-4: Financial Regulation / Life and Health § 5: Life and Health §§ 6-7: Licensing § 8: Property and Casualty
Agency Analyst/Drafter of Proposal: §§ 1-4: Kristin Campanelli, Jon Arsenault § 5: Kristin Campanelli, Mary Ellen Breault §§ 6-7: Kristin Campanelli, Kurt Swan § 8: Mike Malesta, George Bradner

Title of Proposal: AAC Insurance Department Technical Changes
Statutory Reference: §§ 1-4: Conn. Gen. Stat. §38a-175, §38a-176, §38a-179, §38a-180 § 5: Conn. Gen. Stat. §38a-472f(a) §§ 6-7: Conn. Gen. Stat. §38a-479aa, §38a-11 § 8: Conn. Gen. Stat. §38a-395
Proposal Summary: • ***Sections 1-4: Technical Changes to the Statutes Governing Single Purpose Dental HMOs*** • ***Section 5: Technical Change to the Statutes Governing Network Adequacy*** • ***Sections 6 & 7: Technical Changes to the Statutes Governing Preferred Provider Networks*** • ***Section 8: Due Date Change on an Agency Report***

Sections 1-4: Technical Changes to the Statutes Governing Single Purpose Dental HMOs

Sections 1 – 4: PA 16-213, Sections 20-24 (pertaining to licensure of single purpose dental health care centers had a drafting error as it went through the process. These sections have inconsistent references to "sections 38a-175 to 38a-192, inclusive" and "38a-175 to 38a-194, inclusive" – these changes clarify that all of the references state "sections 38a-175 to 38a-194, inclusive" as intended.

Section 5: Technical Change to the Statutes Governing Network Adequacy

Section 5: PA 16-205, Network Adequacy, had a drafting error. This correction explicitly includes dental and vision carriers, as was the legislative intent of the bill as it went through the process.

Sections 6 & 7: Technical Changes to the Statutes Governing Preferred Provider Networks

Sections 6 – 7: These include technical updates to the licensing standards for PPNs to current needs; an option for a requirement of minimum net worth would increase from $250,000 to $500,000, the application date would move from March 1st to May 1st, license renewals would move from May 1st to July 1st, and the fee would increase from $2,750 to $5,000. Tightening up the fees will ensure solvency and ensure that PPNs are viable.

Section 8: Due Date Change on an Agency Report

Section 8: This section amends Conn. Gen. Stat. § 38a-395 to change the due date of the Medical Malpractice report in 38a-395(d).

PROPOSAL BACKGROUND

◊ Reason for Proposal

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? **Yes: Sections 1-4 makes technical corrections to PA 16-213 (Dental HMOs); Section 5 makes a technical correction to PA 16-205 (Network Adequacy).**

(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?* **CID would likely pursue passage of these corrections in future sessions.**

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

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

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

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation? What was the last action taken during the past legislative session?

Click here to enter text.

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Click here to enter text.
Agency Contact (*name, title, phone*): Click here to enter text.
Date Contacted: Click here to enter text.

Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**

Summary of Affected Agency's Comments
Click here to enter text.

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
Section 7 – minor revenue gain.

Federal
None

Additional notes on fiscal impact
Click here to enter text.

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

Sections 1 – 4: This is a technical fix that corrects the law to reflect the legislative intent of the bill.

Section 5: Statute would clarify that dental and vision carriers are to comply with network adequacy requirements, as was intended.

Sections 6 – 7: These technical changes update the regulatory requirements of PPNs to ensure solvency and viability – a consumer protection.

Section 8: Conn. Gen. Stat. § 38a-395 is amended to change the due date of the Medical Malpractice report in 38a-395(d) because data is not available in time for the March 15th due date. The Department will not have a problem submitting this report on or before June 30th.

Insert fully drafted bill here

Section 1. Section 38a-175 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2017):

As used in this section and sections 38a-176 to 38a-194, inclusive, as amended by this act:

(1) "Healing arts" means the professions and occupations licensed under the provisions of chapters 370, 372, 373, 375, 378, 379, 379a, 380, 381, 383 and 400j.

(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 that 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 amended from time to time, or any successor thereto relating to qualified health maintenance organizations.

(6) "Group contract" means a contract for health care services that 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) For a health care center that provides medical and surgical services other than or in addition to dental services, (i) medical, surgical and dental care provided through licensed practitioners, including any supporting and ancillary personnel, services and supplies; (ii) physical therapy service provided through licensed physical therapists upon the prescription of a physician; (iii) psychological examinations provided by registered psychologists; (iv) optometric service provided by licensed optometrists; (v) hospital service, both inpatient and outpatient; (vi) convalescent institution care and nursing home care; (vii) nursing service provided by a registered nurse or by a licensed practical nurse; (viii) home care service of all types required for the health of a person; (ix) rehabilitation service required or desirable for the health of a person; (x) preventive medical services of all and any types; (xi) furnishing necessary appliances, drugs, medicines and supplies; (xii) educational services for the health and well-being of a person; (xiii) ambulance service; and (xiv) 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; and (B) for a health care center that provides only dental services, dental care provided through licensed practitioners, including any supporting and ancillary personnel, services and supplies.

(9) "Health care center" means (A) any organization governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, and licensed or authorized by the commissioner pursuant to section 38a-41 or 38a-41a, for the purpose of carrying out the activities and purposes set forth in subsection (b) of section 38a-176, as amended by this act, at the expense of the health care center, including the providing of health care 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, as amended by this act.

(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 that 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, with respect to an organization, 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 that term is used 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 health care center's insolvency, and for which no alternative arrangements have been made that are acceptable to the commissioner. "Uncovered expenditures" does 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, that 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. 2. Section 38a-176 of the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2017):

(a) Each health care center shall be governed by sections 38a-175 to 38a-194, inclusive, as amended by this act, and by the other applicable laws of the state to the extent not inconsistent with the provisions of said sections.

(b) (1) 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: (A) Establishing, maintaining and operating facilities whereby health care may be provided at the expense of the health care center; and (B) providing health care (i) directly by its health care center employees who, when required by law, shall be duly licensed to render such service, or (ii) 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 (iii) by both methods set forth in subparagraphs (B)(i) and (B)(ii) of this subdivision.

(2) For a health care center that provides medical and surgical services other than or in addition to dental services, the nature of the activities to be conducted and the purposes to be carried out by such health care center, in addition to those set forth in subdivision (1) of this subsection, include, but are not limited to: (A) 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; (B) 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; (C) marketing, enrolling and administering a health care plan; (D) contracting with insurers licensed in this state, including hospital service corporations and medical service corporations; (E) offering, in addition to health services, benefits covering out-of-area or emergency services; (F) providing health services not included in the health care plan on a fee-for-service basis; and (G) entering into contracts in furtherance of the purposes of sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act.

(3) A health care center that provides only dental services shall not be required to conduct activities set forth in subdivision (2) of this subsection.

Sec. 3. Section 38a-179 of the general statutes, is repealed and the following is substituted in lieu thereof (Effective July 1, 2017):

(a) If a domestic 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**]** 38a-194, inclusive, as amended by this act. 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, except for a health care center that provides only dental services, one-quarter of the board of directors shall be persons engaged in the dental or related fields; and (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 a domestic 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 such 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.

Sec. 4. Section 38a-180 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) Any clinic established under sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, including a clinic that 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 said commissioner 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**]** 38a-194, inclusive, as amended by this act, shall not be subject to reprimand or discipline because such person is an employee of the health care center or because such health care center may be engaged in rendering health care or related care through its own employees, except such person shall otherwise remain subject to reprimand or discipline by the state regulating board governing such profession or occupation as provided by law for such person's act or acts for unlawful, unprofessional or immoral conduct.

(c) (1) No health care center that provides medical and surgical services other than or in addition to dental services that contracts with an individual practice association may prohibit any practitioner of the healing arts from participating in such health care center solely on the basis of such practitioner's

profession. No person may interfere with the exercise by any other person of his or her free choice in the selection of a practitioner of the healing arts who is participating in the health care center.

(2) No health care center that provides only dental services that contracts with an individual practice association may prohibit any practitioner of the healing arts from participating in such health care center solely on the basis of such practitioner's profession if such practitioner is licensed to perform services offered by such health care center. No person may interfere with the exercise by any other person of his or her free choice in the selection of a practitioner of the healing arts who is participating in the health care center.

Sec. 5. Section 38a-472f(a) of the general statutes is repealed and the following is substituted in lieu thereof (Effective upon passage):

(a) As used in this section:

(1) "Authorized representative" means (A) an individual to whom a covered person has given express written consent to represent the covered person, (B) an individual authorized by law to provide substituted consent for a covered person, or (C) the covered person's treating health care provider when the covered person is unable to provide consent or a family member of the covered person;

(2) "Covered benefit" or "benefit" means those health care services to which a covered person is entitled under the terms of a health benefit plan;

(3) "Covered person" has the same meaning as provided in section 38a-591a;

(4) "Essential community provider" means a health care provider or facility that (A) serves predominantly low-income, medically underserved individuals and includes covered entities, as defined in 42 USC 256b, as amended from time to time, or (B) is described in 42 USC 1396r-8(c)(1)(D)(i)(IV), as amended from time to time;

(5) "Facility" has the same meaning as provided in section 38a-591a;

(6) "Health benefit plan" has the same meaning as provided in section 38a-591a, except that it includes limited scope dental and vision benefits;

(7) "Health care provider" has the same meaning as provided in section 38a-477aa;

(8) "Health care services" has the same meaning as provided in section 38a-478;

(9) "Health carrier" has the same meaning as provided in section 38a-591a;

(10) "Intermediary" means a person, as defined in section 38a-1, authorized to negotiate and execute health care provider contracts with health carriers on behalf of health care providers or a network;

(11) "Network" means the group or groups of participating providers providing health care services under a network plan;

(12) "Network plan" means a health benefit plan that requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use, health care providers or facilities that are managed, owned, under contract with or employed by the health carrier;

(13) "Participating provider" means a health care provider or a facility that, under a contract with a health carrier or such health carrier's contractor or subcontractor, has agreed to provide health care services to such health carrier's covered persons, with an expectation of receiving payment or reimbursement directly or indirectly from the health carrier, other than coinsurance, copayments or deductibles;

(14) "Primary care" means health care services for a range of common physical, mental or behavioral health conditions, provided by a health care provider;

(15) "Primary care provider" means a participating health care provider designated by a health carrier to supervise, coordinate or provide initial health care services or continuing health care services to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services provided to the covered person;

(16) "Specialist" means a health care provider who (A) focuses on a specific area of physical, mental or behavioral health or a specific group of patients, and (B) has successfully completed required training and is recognized by this state to provide specialty care. "Specialist" includes a subspecialist who has additional training and recognition beyond that required for a specialist;

(17) "Specialty care" means advanced medically necessary care and treatment of specific physical, mental or behavioral health conditions, or those conditions that may manifest in particular ages or subpopulations, that are provided by a specialist in coordination with a health care provider; and

(18) "Tiered network" means a network that identifies and groups some or all types of health care providers and facilities into specific groups to which different participating provider reimbursement, covered person cost-sharing or participating provider access requirements, or any combination thereof, apply for the same health care services.

Sec. 6. Section 38a-479aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):
Sec. 38a-479aa. Preferred provider networks. Definitions. Licensing. Fees. Requirements. Exception, regulations. (a) As used in this part and subsection (b) of section 20-138b:

(1) "Covered benefits" means health care services to which an enrollee is entitled under the terms of a managed care plan;

(2) "Enrollee" means an individual who is eligible to receive health care services through a preferred provider network;

(3) "Health care services" means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal authorization, and includes hospital, medical, surgical, dental, vision and pharmaceutical services or products;

(4) "Managed care organization" means (A) a managed care organization, as defined in section 38a-478, (B) any other health insurer, or (C) a reinsurer with respect to health insurance;

(5) "Managed care plan" means a managed care plan, as defined in section 38a-478;

(6) "Person" means an individual, agency, political subdivision, partnership, corporation, limited liability company, association or any other entity;

(7) "Preferred provider network" means a person, which is not a managed care organization, but which pays claims for the delivery of health care services, accepts financial risk for the delivery of health care services and establishes, operates or maintains an arrangement or contract with providers relating to (A) the health care services rendered by the providers, and (B) the amounts to be paid to the providers for such services. "Preferred provider network" does not include (i) a workers' compensation preferred provider organization established pursuant to section 31-279-10 of the regulations of Connecticut state agencies, (ii) an independent practice association or physician hospital organization whose primary function is to contract with insurers and provide services to providers, (iii) a clinical laboratory, licensed pursuant to section 19a-30, whose primary payments for any contracted or referred services are made to other licensed clinical laboratories or for associated pathology services, or (iv) a pharmacy benefits manager responsible for administering pharmacy claims whose primary function is to administer the pharmacy benefit on behalf of a health benefit plan;

(8) "Provider" means an individual or entity duly licensed or legally authorized to provide health care services; and

(9) "Commissioner" means the Insurance Commissioner.

(b) On and after **[**May 1, 2004**]** July 1, 2017, no preferred provider network may enter into or renew a contractual relationship with a managed care organization unless the preferred provider network is licensed by the commissioner. On and after **[**May 1, 2005**]** July 1, 2017, no preferred provider network may conduct business in this state unless it is licensed by the commissioner. Any person seeking to obtain or renew a license shall submit an application to the commissioner, on such form as the commissioner may prescribe, and shall include the filing described in this subsection, except that a person seeking to renew a license may submit only the information necessary to update its previous filing. Applications shall be submitted by **[**March**]** May first of each year in order to qualify for the **[**May**]** July first license issue or renewal date. The filing required from such preferred provider network shall include the following information: (1) The identity of the preferred provider network and any company or organization controlling the operation of the preferred provider network, including the name, business address, contact person, a description of the controlling company or organization and, where applicable, the following: (A) A certificate from the Secretary of the State regarding the preferred provider network's and the controlling company's or organization's good standing to do business in the state; (B) a copy of the preferred provider network's and the controlling company's or organization's financial statement completed in accordance with sections 38a-53 and 38a-54, as applicable, for the end of its most recently concluded fiscal year, along with the name and address of any public accounting firm or internal accountant which prepared or assisted in the preparation of such financial statement; (C) a list of the names, official positions and occupations of members of the preferred provider network's and the controlling company's or organization's board of directors or other policy-making body and of those executive officers who are responsible for the preferred provider network's and controlling company's or organization's activities with respect to the health care services network; (D) a list of the preferred provider network's and the controlling company's or organization's principal owners; (E) in the case of an out-of-state preferred provider network, controlling company or organization, a certificate that such preferred provider network, company or organization is in good standing in its state of organization; (F) in the case of a Connecticut or out-of-state preferred provider network, controlling company or organization, a report of the details of any suspension, sanction or other disciplinary action relating to such preferred provider network, or controlling company or organization in this state or in any other state; and (G) the identity, address and current relationship of any related or predecessor controlling company or organization. For purposes of this subparagraph, "related" means that a substantial number of the board or policy-making body members, executive officers or principal owners of both companies are the same; (2) a general description of the preferred provider network and participation in the preferred provider network, including: (A) The geographical service area of and the names of the hospitals included in the preferred provider network; (B) the primary care physicians, the specialty physicians, any other contracting providers and the number and percentage of each group's capacity to accept new patients; (C) a list of all entities on whose behalf the preferred provider network has contracts or agreements to provide health care services; (D) a table listing all major categories of health care services provided by the preferred provider network; (E) an approximate number of total enrollees served in all of the preferred provider network's contracts or

agreements; (F) a list of subcontractors of the preferred provider network, not including individual participating providers, that assume financial risk from the preferred provider network and to what extent each subcontractor assumes financial risk; (G) a contingency plan describing how contracted health care services will be provided in the event of insolvency; and (H) any other information requested by the commissioner; and (3) the name and address of the person to whom applications may be made for participation.

(c) Any person developing a preferred provider network, or expanding a preferred provider network into a new county, pursuant to this section and subsection (b) of section 20-138b, shall publish a notice, in at least one newspaper having a substantial circulation in the service area in which the preferred provider network operates or will operate, indicating such planned development or expansion. Such notice shall include the medical specialties included in the preferred provider network, the name and address of the person to whom applications may be made for participation and a time frame for making application. The preferred provider network shall provide the applicant with written acknowledgment of receipt of the application. Each complete application shall be considered by the preferred provider network in a timely manner.

(d) (1) Each preferred provider network shall file with the commissioner and make available upon request from a provider the general criteria for its selection or termination of providers. Disclosure shall not be required of criteria deemed by the preferred provider network to be of a proprietary or competitive nature that would hurt the preferred provider network's ability to compete or to manage health care services. For purposes of this section, criteria is of a proprietary or competitive nature if it has the tendency to cause providers to alter their practice pattern in a manner that would circumvent efforts to contain health care costs and criteria is of a proprietary nature if revealing the criteria would cause the preferred provider network's competitors to obtain valuable business information.

(2) If a preferred provider network uses criteria that have not been filed pursuant to subdivision (1) of this subsection to judge the quality and cost-effectiveness of a provider's practice under any specific program within the preferred provider network, the preferred provider network may not reject or terminate the provider participating in that program based upon such criteria until the provider has been informed of the criteria that the provider's practice fails to meet.

(e) Each preferred provider network shall permit the Insurance Commissioner to inspect its books and records.

(f) Each preferred provider network shall permit the commissioner to examine, under oath, any officer or agent of the preferred provider network or controlling company or organization with respect to the use of the funds of the preferred provider network, company or organization, and compliance with (1) the provisions of this part, and (2) the terms and conditions of its contracts to provide health care services.

(g) Each preferred provider network shall file with the commissioner a notice of any material modification of any matter or document furnished pursuant to this part, and shall include such supporting documents as are necessary to explain the modification.

(h) Each preferred provider network shall maintain a minimum net worth of either (1) the greater of (A) **[**two hundred fifty**]** five hundred thousand dollars, or (B) an amount equal to eight per cent of its annual expenditures as reported on its most recent financial statement completed and filed with the commissioner in accordance with sections 38a-53 and 38a-54, as applicable, or (2) another amount determined by the commissioner.

(i) Each preferred provider network shall maintain or arrange for a letter of credit, bond, surety, reinsurance, reserve or other financial security acceptable to the commissioner for the exclusive use of paying any outstanding amounts owed participating providers in the event of insolvency or nonpayment except that any remaining security may be used for the purpose of reimbursing managed care organizations in accordance with subsection (b) of section 38a-479bb. Such outstanding amount shall be at least an amount equal to the greater of (1) an amount sufficient to make payments to participating providers for **[**two**]** four months determined on the basis of the **[**two**]** four months within the past year with the greatest amounts owed by the preferred provider network to participating providers, (2) the actual outstanding amount owed by the preferred provider network to participating providers, or (3) another amount determined by the commissioner. Such amount may be credited against the preferred provider network's minimum net worth requirements set forth in subsection (h) of this section. The commissioner shall review such security amount and calculation on a quarterly basis.

(j) Each preferred provider network shall pay the applicable license or renewal fee specified in section 38a-11. The commissioner shall use the amount of such fees solely for the purpose of regulating preferred provider networks.

(k) In no event, including, but not limited to, nonpayment by the managed care organization, insolvency of the managed care organization, or breach of contract between the managed care organization and the preferred provider network, shall a preferred provider network bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an enrollee or an enrollee's designee, other than the managed care organization, for covered benefits provided, except that the preferred provider network may collect any copayments, deductibles or other out-of-pocket expenses that the enrollee is required to pay pursuant to the managed care plan.

(l) Each contract or agreement between a preferred provider network and a participating provider shall contain a provision that if the preferred provider network fails to pay for health care services as set forth in the contract, the enrollee shall not be liable to the participating provider for

any sums owed by the preferred provider network or any sums owed by the managed care organization because of nonpayment by the managed care organization, insolvency of the managed care organization or breach of contract between the managed care organization and the preferred provider network.

(m) Each utilization review determination made by or on behalf of a preferred provider network shall be made in accordance with section 38a-591d.

(n) The requirements of subsections (h) and (i) of this section shall not apply to a consortium of federally qualified health centers funded by the state, providing services only to recipients of programs administered by the Department of Social Services. The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to establish criteria to certify any such federally qualified health center, including, but not limited to, minimum reserve fund requirements.

Sec. 7. Section 38a-11(a) of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

Sec. 38a-11. (Formerly Sec. 38-50). (a) The commissioner shall demand and receive the following fees: (1) For the annual fee for each license issued to a domestic insurance company, two hundred dollars; (2) for receiving and filing annual reports of domestic insurance companies, fifty dollars; (3) for filing all documents prerequisite to the issuance of a license to an insurance company, two hundred twenty dollars, except that the fee for such filings by any health care center, as defined in section 38a-175, shall be one thousand three hundred fifty dollars; (4) for filing any additional paper required by law, thirty dollars; (5) for each certificate of valuation, organization, reciprocity or compliance, forty dollars; (6) for each certified copy of a license to a company, forty dollars; (7) for each certified copy of a report or certificate of condition of a company to be filed in any other state, forty dollars; (8) for amending a certificate of authority, two hundred dollars; (9) for each license issued to a rating organization, two hundred dollars. In addition, insurance companies shall pay any fees imposed under section 12-211; (10) a filing fee of fifty dollars for each initial application for a license made pursuant to section 38a-769; (11) with respect to insurance agents' appointments: (A) A filing fee of fifty dollars for each request for any agent appointment, except that no filing fee shall be payable for a request for agent appointment by an insurance company domiciled in a state or foreign country which does not require any filing fee for a request for agent appointment for a Connecticut insurance company; (B) a fee of one hundred dollars for each appointment issued to an agent of a domestic insurance company or for each appointment continued; and (C) a fee of eighty dollars for each appointment issued to an agent of any other insurance company or for each appointment continued, except that (i) no fee shall be payable for an appointment issued to an agent of an insurance company domiciled in a state or foreign country which does not require any fee for an appointment issued to an agent of a Connecticut insurance company, and (ii) the fee shall be twenty dollars for each appointment issued or continued to an agent of an insurance company domiciled in a state or foreign country with a premium tax rate below Connecticut's premium tax rate; (12) with respect to insurance producers: (A) An examination fee of fifteen dollars for each examination taken,

except when a testing service is used, the testing service shall pay a fee of fifteen dollars to the commissioner for each examination taken by an applicant; (B) a fee of eighty dollars for each license issued; (C) a fee of eighty dollars per year, or any portion thereof, for each license renewed; and (D) a fee of eighty dollars for any license renewed under the transitional process established in section 38a-784; (13) with respect to public adjusters: (A) An examination fee of fifteen dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of fifteen dollars to the commissioner for each examination taken by an applicant; and (B) a fee of two hundred fifty dollars for each license issued or renewed; (14) with respect to casualty claims adjusters: (A) An examination fee of twenty dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of twenty dollars to the commissioner for each examination taken by an applicant; (B) a fee of eighty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner two hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (15) with respect to motor vehicle physical damage appraisers: (A) An examination fee of eighty dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of eighty dollars to the commissioner for each examination taken by an applicant; (B) a fee of eighty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner two hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (16) with respect to certified insurance consultants: (A) An examination fee of twenty-six dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of twenty-six dollars to the commissioner for each examination taken by an applicant; (B) a fee of two hundred fifty dollars for each license issued; and (C) a fee of two hundred fifty dollars for each license renewed; (17) with respect to surplus lines brokers: (A) An examination fee of twenty dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of twenty dollars to the commissioner for each examination taken by an applicant; and (B) a fee of six hundred twenty-five dollars for each license issued or renewed; (18) with respect to fraternal agents, a fee of eighty dollars for each license issued or renewed; (19) a fee of twenty-six dollars for each license certificate requested, whether or not a license has been issued; (20) with respect to domestic and foreign benefit societies shall pay: (A) For service of process, fifty dollars for each person or insurer to be served; (B) for filing a certified copy of its charter or articles of association, fifteen dollars; (C) for filing the annual report, twenty dollars; and (D) for filing any additional paper required by law, fifteen dollars; (21) with respect to foreign benefit societies: (A) For each certificate of organization or compliance, fifteen dollars; (B) for each certified copy of permit, fifteen dollars; and (C) for each copy of a report or certificate of condition of a society to be filed in any other state, fifteen dollars; (22) with respect to reinsurance intermediaries, a fee of six hundred twenty-five dollars for each license issued or renewed; (23) with respect to life settlement providers: (A) A filing fee of twenty-six dollars for each initial application for a license made pursuant to section 38a-465a; and (B) a fee of forty dollars for each license issued or renewed; (24) with respect to life settlement brokers: (A) A filing fee

of twenty-six dollars for each initial application for a license made pursuant to section 38a-465a; and (B) a fee of forty dollars for each license issued or renewed; (25) with respect to preferred provider networks, a fee of **[**two thousand seven hundred fifty dollars**]** five thousand dollars for each license issued or renewed; (26) with respect to rental companies, as defined in section 38a-799, a fee of eighty dollars for each permit issued or renewed; (27) with respect to medical discount plan organizations licensed under section 38a-479rr, a fee of six hundred twenty-five dollars for each license issued or renewed; (28) with respect to pharmacy benefits managers, an application fee of one hundred dollars for each registration issued or renewed; (29) with respect to captive insurance companies, as defined in section 38a-91aa, a fee of three hundred seventy-five dollars for each license issued or renewed; (30) with respect to each duplicate license issued a fee of fifty dollars for each license issued; (31) with respect to surety bail bond agents, as defined in section 38a-660, (A) a filing fee of one hundred fifty dollars for each initial application for a license, and (B) a fee of one hundred dollars for each license issued or renewed; (32) with respect to third-party administrators, as defined in section 38a-720, (A) a fee of five hundred dollars for each license issued, and (B) a fee of four hundred fifty dollars for each license renewed; and (33) with respect to portable electronics insurance licenses under section 38a-397, (A) a filing fee of one hundred dollars for each initial application for a license, (B) a fee of five hundred dollars for each license issued, and (C) a fee of four hundred fifty dollars for each license renewed.

(b) If any state imposes fees upon domestic fraternal benefit societies greater than are fixed by this section or sections 38a-595 to 38a-626, inclusive, 38a-631 to 38a-640, inclusive, or 38a-800, the commissioner shall collect from each fraternal benefit society incorporated by or organized under the laws of such other state and admitted to transact business in this state, the same fees as are imposed upon similar domestic societies and organizations by such other state. The expense of any examination or inquiry made outside the state shall be borne by the society so examined.

(c) Each unauthorized insurer declared to be an eligible surplus lines insurer shall pay to the Insurance Commissioner, on or before May first of each year, an annual fee of one hundred twenty-six dollars in order to remain on the list of eligible surplus lines insurers.

(d) For service of process on the commissioner, the commissioner shall demand and receive a fee of fifty dollars for each person or insurer to be served. The commissioner shall also collect, for each hospital or ambulance lien filed, fifty dollars, and for each small claims notice filed, fifteen dollars, each of which shall be paid by the plaintiff at the time of service, the same to be recovered by him as part of the taxable costs if he prevails in the suit.

(e) Each insurance company depositing any security with the Treasurer pursuant to section 38a-83 shall pay to the commissioner three hundred fifteen dollars, annually. In case of an examination or appraisal made outside the office of the Treasurer, and in such case the company in whose behalf such examination or appraisal has been made shall pay to the commissioner two hundred dollars for such examination and the actual traveling expenses of the officer making such examination or appraisal.

Sec. 8. Section 38a-395 of the general statutes is repealed and the following is substituted in lieu thereof (Effective June 30, 2017):

Sec. 38a-395. (Formerly Sec. 38-370d). Medical malpractice data: Closed claims reports. Database. Annual report. (a) As used in this section:

(1) "Claim" means a request for indemnification filed by a medical professional or hospital pursuant to a professional liability policy for a loss for which a reserve amount has been established by an insurer;

(2) "Closed claim" means a claim that has been settled, or otherwise disposed of, where the insurer has made all indemnity and expense payments on the claim;

(3) "Insurer" means an insurer that insures a medical professional or hospital against professional liability. "Insurer" includes, but is not limited to, a captive insurer or a self-insured person; and

(4) "Medical professional" has the same meaning as provided in section 38a-976.

(b) On and after January 1, 2006, each insurer shall provide to the Insurance Commissioner a closed claim report, on such form as the commissioner prescribes, in accordance with this section. The insurer shall submit the report not later than ten days after the last day of the calendar quarter in which a claim is closed. The report shall only include information about claims settled under the laws of this state.

(c) The closed claim report shall include:

(1) Details about the insured and insurer, including: (A) The name of the insurer; (B) the professional liability insurance policy limits and whether the policy was an occurrence policy or was issued on a claims-made basis; (C) the name, address, health care provider professional license number and specialty coverage of the insured; and (D) the insured's policy number and a unique claim number.

(2) Details about the injury or loss, including: (A) The date of the injury or loss that was the basis of the claim; (B) the date the injury or loss was reported to the insurer; (C) the name of the institution or location at which the injury or loss occurred; (D) the type of injury or loss, including a severity of injury rating that corresponds with the severity of injury scale that the Insurance Commissioner shall establish based on the severity of injury scale developed by the National Association of Insurance Commissioners; and (E) the name, age and gender of any injured person covered by the claim. Any individually identifiable health information, as defined in 45 CFR 160.103, as from time to time amended, submitted pursuant to this subdivision shall be confidential. The reporting of the information is required by law. If necessary to comply with federal privacy laws, including the Health Insurance Portability and Accountability Act of 1996, (P.L. 104-191) (HIPAA), as from time to time amended, the insured shall arrange with the insurer to release the required information.

(3) Details about the claims process, including: (A) Whether a lawsuit was filed and, if so, in which court; (B) the outcome of such lawsuit; (C) the number of other defendants, if any; (D) the stage in the process when the claim was closed; (E) the dates of the trial, if any; (F) the date of the judgment or settlement, if any; (G) whether an appeal was filed and, if so, the date filed; (H) the resolution of any appeal and the date such appeal was decided; (I) the date the claim was closed; (J) the initial indemnity and expense reserve for the claim; and (K) the final indemnity and expense reserve for the claim.

(4) Details about the amount paid on the claim, including: (A) The total amount of the initial judgment rendered by a jury or awarded by the court; (B) the total amount of the settlement if there was no judgment rendered or awarded; (C) the total amount of the settlement if the claim was settled after judgment was rendered or awarded; (D) the amount of economic damages, as defined in section 52-572h, or the insurer's estimate of the amount in the event of a settlement; (E) the amount of noneconomic damages, as defined in section 52-572h, or the insurer's estimate of the amount in the event of a settlement; (F) the amount of any interest awarded due to the failure to accept an offer of judgment or compromise; (G) the amount of any remittitur or additur; (H) the amount of final judgment after remittitur or additur; (I) the amount paid by the insurer; (J) the amount paid by the defendant due to a deductible or a judgment or settlement in excess of policy limits; (K) the amount paid by other insurers; (L) the amount paid by other defendants; (M) whether a structured settlement was used; (N) the expense assigned to and recorded with the claim, including, but not limited to, defense and investigation costs, but not including the actual claim payment; and (O) any other information the commissioner determines to be necessary to regulate the professional liability insurance industry with respect to medical professionals or hospitals, ensure the industry's solvency and ensure that such liability insurance is available and affordable.

(d) (1) The commissioner shall establish an electronic database composed of closed claim reports filed pursuant to this section.

(2) The commissioner shall compile the data included in individual closed claim reports into an aggregated summary format and shall prepare a written annual report of the summary data. The report shall provide an analysis of closed claim information including a minimum of five years of comparative data, when available, trends in frequency and severity of claims, itemization of damages, timeliness of the claims process, and any other descriptive or analytical information that would assist in interpreting the trends in closed claims.

(3) The annual report shall include a summary of rate filings for professional liability insurance for medical professionals or hospitals, which have been approved by the department for the prior calendar year, including an analysis of the trend of direct losses, incurred losses, earned premiums and investment income as compared to prior years. The report shall include base premiums charged by insurers for each specialty and the number of providers insured by specialty for each insurer.

(4) Not later than [March 15, 2007] <u>June 30, 2017</u>, and annually thereafter, the commissioner shall submit the annual report to the joint standing committee of the General Assembly having

cognizance of matters relating to insurance in accordance with section 11-4a. The commissioner shall also (A) make the report available to the public, (B) post the report on its Internet site, and (C) provide public access to the contents of the electronic database after the commissioner establishes that the names and other individually identifiable information about the claimant and practitioner have been removed.

(e) The Insurance Commissioner shall provide the Commissioner of Public Health with electronic access to all information received pursuant to this section. The Commissioner of Public Health shall maintain the confidentiality of such information in the same manner and to the same extent as required for the Insurance Commissioner.

Agency Legislative Proposal - 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **DRAFT CID 2017 AAC Surety Bail Bond Agents**

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

State Agency: Connecticut Insurance Department
Liaison: Eric Weinstein **Phone:** 860/297-3864 **E-mail:** Eric.Weinstein@ct.gov
Lead agency division requesting this proposal: Market Conduct
Agency Analyst/Drafter of Proposal: Tony Caporale, Kurt Swan

Title of Proposal: AAC Surety Bail Bond Agents
Statutory Reference: §38a-660(k), §38a-660m
Proposal Summary: This bill would give the Department a full calendar year access to the funds needed to audit bail bondsmen. Current law requires bondsmen to pay $450 when renewing their licenses on January 31. That money has been subject to sweeps by the end of the fiscal year giving the Department only five months, thus reducing the effectiveness of the Department's oversight – this short window was noted by the State Auditors of Public Accounts in a recent audit of the Department. This proposal will cause the license of a surety bail bond agent to automatically expire on February 1st if the surety bail bond agent fails to pay the $450 fee by the renewal date, and the license will be immediately reinstated if the fee is received not later than 10 days after the expiration of the license. This proposal also establishes authority to adopt regulations to establish continuing education requirement for persons licensed as surety bail bond agents.

PROPOSAL BACKGROUND

- ◊ **Reason for Proposal**

Please consider the following, if applicable:

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

(2) *Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?* **Many other states have continuing education requirements**

(3) *Have certain constituencies called for this action?* **The Auditors of Public Accounts have recommended changing the sweep date of the funds.**

(4) *What would happen if this was not enacted in law this session?* **Revocation of licenses would continue to be costly and time consuming. Funds established to audit agents would be prematurely sent to the general fund.**

Click here to enter text.

◊ **Origin of Proposal** ☐ **New Proposal** ☒ **Resubmission** 2016 sHB 5232 File No. 134

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?* ***This bill passed the House unanimously but died on the Senate Calendar.***

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

(3) *Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?* **The Department worked with the Bail Association of Connecticut who was supportive of this language.**
What was the last action taken during the past legislative session? ***2016 HB 5235 passed the House unanimously on April 22nd but died on the Senate Calendar, Calendar #485.***

Click here to enter text.

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Click here to enter text.
Agency Contact (*name, title, phone*): Click here to enter text.
Date Contacted: Click here to enter text.

Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**

Summary of Affected Agency's Comments
Click here to enter text.

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 Minimal (CID will retain funds longer before they are swept into the General Fund
Federal None
Additional notes on fiscal impact Click here to enter text.

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

Currently surety bond agents are required to pay a licensing fee to the Insurance Department by the 31st of January every year. The proposal establishes automatic expiration of those licenses if such fee is not paid on time and includes a grace period. The Insurance Commissioner is required to annually notify surety bail bonds agents of this policy. The proposal also requires an establishment of continuing education requirements for licensed surety bail bond agents.

The proposal also moves the sweep date of the surety bail bond agent examination account from the end of the fiscal year to the end of the calendar year. The Insurance Department has requested this change because licenses are renewed in January, and therefore the funding is only available for six months.

This would also require the Commissioner to adopt regulations concerning continuing education requirements.

Insert fully drafted bill here

Section 1. Subsection (k) of section 38a-660 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(k) (1) (A) To further the enforcement of this section and sections 38a-660b to 38a-660m, inclusive, as amended by this act, and to determine the eligibility of any licensee, the commissioner may, as often as the commissioner deems necessary, examine the books and records of any such

licensee. Each person licensed as a surety bail bond agent in this state shall, on or before January thirty-first, annually, pay to the commissioner a fee of four hundred fifty dollars to cover the cost of examinations under this subsection.

(B) If such person fails to pay such fee on or before January thirty-first, annually, the license of such person shall automatically expire on the February first immediately following, provided the commissioner shall immediately reinstate any such license if the commissioner receives such fee not later than ten days after such expiration.

(C) The commissioner shall notify, not later than December fifteenth, annually, each person licensed as a surety bail bond agent in this state about such automatic expiration provision.

(2) The fees received by the commissioner pursuant to subdivision (1) of this subsection shall be dedicated to conducting the examinations under said subdivision (1) and shall be deposited in the account established under subdivision (3) of this subsection.

(3) There is established an account to be known as the "surety bail bond agent examination account", which shall be a separate, nonlapsing account within the Insurance Fund established under section 38a-52a. The account shall contain any moneys required by law to be deposited in the account and any such moneys remaining in the account at the **[**close of the fiscal**]** end of each calendar year shall be transferred to the General Fund.

Sec. 2. Section 38a-660m of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to (1) implement the provisions of section 38a-660, as amended by this act, and sections 38a-660b to 38a-660k, inclusive, and (2) establish continuing education requirements for persons licensed as surety bail bond agents in this state.